HEALTH CARE POLICY and REFORM

A Comparative Study of Policy Making and the Health Care Systems in Five OECD Countries

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ABSTRACT

Many of the assumptions underlying health care issues appear to be taken for granted by policy makers, when if fact they ought to be examined for their relevance to today’s problems. This research attempts to do so, by analysing the non-economic issues and factors involved in the financing and provision of health care. It will be argued that policy makers commonly have a unidirectional economic perspective in both policy making and in health care system reform directives, a situation which leaves issues such as the health status of the population and of equity in resource allocation to political rhetoric, while in practice, policies deal with the issue of cost reduction. Of major importance is the moral dimension in policies dealing with health and welfare, which is clearly either forgotten or is afforded too little consideration in policy making. This is particularly relevant to the issue of rationing of health care in publicly provided health care systems. While always quietly practised by clinicians in the past, rationing is now required to be overt because demand for health care has outstripped available resources.

The substance of the argument comes from the analysis of a very large literature on the broader issues affecting health care policy, such as concepts of social justice, ethics of resource allocation and the physician-patient relationship, all of which ought to underpin policies for the mechanisms of funding and provision of health care systems.

A conceptual diagram of a health care system is offered to provide a framework for the discussion of how the issues are interrelated at micro, meso and macro levels in policy-making. Examples of reforms to health care systems are taken from five OECD countries which share a common social, political and economic heritage: Australia, United Kingdom, New Zealand, Canada and the United States of America.

The conclusions from this research show that theoretical incoherence pervades this most complex of policy areas, allowing the economic imperative to take precedence over the substantive health care issues.
"Public administration, under the influence of economic rationalism, is in danger of being turned into a mere auxiliary of the international market and monetary system. As a consequence, the distinctive tasks and responsibilities of government are being forgotten, and the change is being justified by some bad economic theorising."

(Self 1995, p.341)
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GLOSSARY & ACRONYMS

AGENCY MODEL  The relationship between patient and doctor in which the doctor supplies technical expertise and subordinates his/her own interests to the interests of the patient when diagnosing, prescribing and treating.

AIH  Australian Institute of Health (1987-1992); now AIH&W, q.v. An independent statistics and research agency within the Commonwealth Human Services & Health portfolio. Its Act was amended in 1992 to expand its role to study welfare-related information and statistics.

AIH & W  Australian Institute of Health and Welfare, 1992 -

AMA  Australian Medical Association; American Medical Association

BASIC HEALTH CARE  A minimum set, or core, of health services: in reality, this concept has proven very difficult, if not impossible, to achieve.

BMA  British Medical Association

BENEFITS  In health insurance, either a payment in cash paid in settlement of a claim under the terms of an indemnity policy or the provision of a service in kind following a medical contingency covered by a scheme.

CAPITATION PAYMENT  A fixed payment to a provider of medical care for each listed or enrolled person served per period of time. Payments will vary according to the number of patients enrolled but not with the number of services rendered per patient.

CASEMIX  A technique which allows hospitals to take into account the different types of services in terms of severity of illness and other variables which are provided, to enable valid comparisons between institutions.

COMPETITION  Rivalry between two or more sellers of health care for revenue, market share or other advantage.

DHFS  Australian Federal Department of Health and Family Services (1996 - )

DHHCS  Australian Federal Department of Health, Housing & Community Services, afterwards Department of Human Services and Health (DHS&H, q.v.)

DHSH  Australian Federal Department of Human Services and Health (1993 - 1996), afterwards Department of Health and Family Services (DHFS, q.v.)
DRG  Diagnosis Related Groups. A classification scheme which groups episodes of treatment in terms of costs.

DRS  Doctors' Reform Society (Australia)

FEE FOR SERVICE  A method of remuneration for providers of health care services.

GATEKEEPER ROLE  The general practitioner or primary care physician is seen as the gatekeeper to the more expensive secondary and tertiary levels of health care, including hospitalisation and the increasingly technological battery of tests available for diagnostic purposes. Three types of gatekeeper have been identified:

1. The de facto gatekeeper, who with "diagnostic elegance and therapeutic parsimony" (Pellegrino & Thomasma) achieve maximum good for the patient at minimum cost.

2. The positive gatekeeper, who increases consumption of health care as a commodity (especially when remuneration structures reward increased consumption).

3. The negative gatekeeper, who rations health care resources, balancing the good of society and of the patient.

GDP  Gross Domestic Product. Used interchangeably with GNP, q.v.

GNP  Gross National Product. Used interchangeably with GDP, q.v.

GLOBAL BUDGET  A prospective budget, an aggregate cash sum, fixed in advance, intended to cover the total cost of a service for a fixed term ahead.

HDWA  Health Department of Western Australia

HEALTH ALLIANCES (USA)  Large pools of insurance purchasers who would use their bargaining power to negotiate the best health care services at the best price. As the administrative basis for his reform plan, President Clinton adapted the idea from managed competition's model of the health insurance purchasing cooperative (HIPC). Alliances would be run by the states which would determine, on the basis of population and resources, how many alliances would be needed and where.

HEALTH OUTCOME  Changes in health status (mortality and morbidity) which result from the provision of health care (or other) services.

HMO  Health maintenance organisation. A legal and commercial entity providing comprehensive health care plans which are offered to members for a given price. Health care providers are usually employed by the HMO, and their clinical autonomy is limited. Central control of costs is paramount. Distinguish between not-for-profit (e.g. Kaiser Permanente) and for-profit HMOs.
IPA Independent practice association. Type of health care plan, loosely organised into a network of independent providers who proffer services to patients at a discounted price. Providers are paid on a fee-for-service basis rather than salary, and they contract with an administrative insurer for HMO patients.

MANAGED CARE Health care delivery system that uses financial checks, incentives and oversight to promote lower-cost treatment. Scope varies widely, from private practitioners who contract with one or more plans, to salaried practitioners in HMOs. Originally used in the USA, developed by Enthoven and Ellwood. GP fundholding in UK has created 'mini' HMOs/managed care in that country.

MANAGED COMPETITION Government regulation of a health care market which uses competition as the means to achieve efficiency objectives within a framework of government intervention designed to achieve other policy objectives, such as equity.

MORAL HAZARD The tendency for insurance cover to encourage risk-taking behaviour by the insured individual and to raise their demand for health care services by lowering the net price of such services. These hazards increase the risk to the insurer and if not checked, are likely to lead to higher claims and higher insurance premiums.

OECD Organisation for Economic Co-operation and Development

OUTCOMES MEASUREMENT Attempts to measure the costs and results of treatments. Started as an attempt by insurance companies and large employers in the USA to measure the efficacy of increasingly costly health care, in particular to identify the most efficient hospitals and physicians. Doubts exist about the ability of analysts to generate data sophisticated enough to judge medical quality and to allocate resources to medical care.

PPO Preferred provider organisation. Network of health care plans similar to IPAs (q.v.) except that they are more loosely organised and have more limited cost control. Members may attend physicians outside the network but will pay more if they do so.

PRACTICE GUIDELINES Treatment procedures arrived at and agreed upon by a medical committee or group for certain common medical conditions. Objectives include helping protect physicians from malpractice liability; reducing the numbers of tests and procedures; assuring agreed-upon quality of care. Criticisms include the threat of 'cookbook' medicine; the inhibition of new or emerging cost-effective treatments; and the dangers of relying on quantitative methodologies in the 'art' of medicine.

PRIMARY CARE In most countries, general practitioners in the 'gatekeeper role' (q.v.) provide primary care as the entry to the health care system. The costs of primary care are much lower than other levels of care. In the USA primary care is important to health care reform proposals because of their increased reliance on preventive medicine
to control health care costs. At best, only 30% of practitioners in the USA could be
categorised as primary care physicians, whereas other countries have at least 50% GPs
to other providers.

SINGLE PAYER A method of paying for health insurance which relies on the
government, e.g. Canada and United Kingdom.

SUPPLIER-INDUCED DEMAND The supposed ability of doctors to boost the
demand for their services or for the services of their colleagues.

References

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You'd better know what they're talking about.
The origin of this thesis stemmed from a desire to firstly understand why it is that health departments can’t seem to ‘get it right’ in terms of balancing the varied needs of everyone in the provision of health care, and secondly to discover why health care policies in many countries have what can only be described as muddled and inequitable results in the organisation of the health care sector. Having been involved in managerial aspects of this part of the public sector as both practitioner and academic, curiosity was engendered by the observation that policies bore results which appeared at odds with stated objectives and this in turn provoked a desire to document the perceived lack of coherence on the part of policy makers/decision takers which appears to give rise to the lack of policy cogency. These factors together with previous research undertaken in related areas, conspired to give the research its impetus and dictated the way in which the research was undertaken. The main task was to find out what the non-economist experts on health care thought were the underlying issues pertaining to health care policy. This involved the reading of a huge literature on the subject. As a result, the structure of the thesis has had to depart from the usual reliance on the collection of primary data and the format of a research report, with its formulation of hypotheses and other statements and the relationships between them. Instead, the research examines what the experts in the field say about different perspectives and factors in health care policy. Gathering at source (i.e. from each expert) all this information, involving hundreds of authors and their work over a decade and more, would have been an impossible task for one researcher, so published sources have been used. The major task of this research involves the analysis of these values, opinions and ideas
together with the interweaving of argument for the conscientious and considered formal inclusion of non-economic factors and issues in future health care policy making and further health care system reform.

*Historical and Personal Factors Influencing Research*

In 1984 the three separate departments together responsible for financing, administering and providing public health care in Western Australia - *Hospitals and Allied Services, Public Health, and Mental Health* were amalgamated into the one large entity: the Health Department of Western Australia (HDWA). From 1974 until this time I worked at a tertiary teaching hospital in a management capacity, acquiring the knowledge and understanding of how hospitals were administered within a health care system. First hand experience was gained of the huge quantities of primary data collected from hospitals by central health departments. Shortly after the amalgamation, the new Labor government under the premiership of Brian Burke embarked on a functional review of government departments, and I was seconded from the hospital to a team in the HDWA to carry out this task. Once this task was completed, I accepted a position as a planning officer in the Information Management Branch of the HDWA. The four years spent here engendered feelings akin to those of Lewis Carroll’s Alice, who, having fallen through the looking glass, found herself in a perpetual mad hatter’s tea-party. At the HDWA I discovered that the data sent in by hospitals, collected by them at no small price, were selectively considered or manipulated to inform policies which bore little relation to the health care needs of the populace. In pursuit of reasons for the perceived incoherence of policies and practice in place in the HDWA, I embarked
on masters degree research. This work showed that unless policy makers were very astute and insightful, then personalities and power structures in institutions would nearly always thwart those objectives which I understood to be germane to the provision of health care, that is ascertaining and providing for the health care needs of individual patients and the population as a whole. Added to this situation was the competition - political, financial and managerial - between state and federal bodies, the lack of management skills in many areas of both the HDWA and the hospitals, and the growing concern about the increasing costs of the provision of health care: it became increasingly clear that confusion would be perpetuated unless cognisance was taken of all these factors. Furthermore, the continual restructuring of the HDWA had lowered the morale of the work-force, and the hospitals continued with their day to day activities in spite of, rather than with the support of, the HDWA. Strategic planning, when it occurred at all, revolved mainly around the Department which appeared to see itself as an end, rather than as a means to an end. Health care dollars were being expended on administration of the department instead of on patient care and maintenance of hospitals and equipment. Hospitals' managements were also sublimating their main objectives and were blatantly empire building, meaning that the treatment needs of the population were being placed second to the growth needs of individual hospitals. In time, the areas of public health and mental health were starved of funds, a situation that even effective leadership, where it was in evidence, could not alter because of the new balance of power within the superdepartment. This research also demonstrated the dangers inherent in the collection, collation and analysis of data in this field. It found, for example, the use of death certificate data for the compilation of statistics for which they were not intended.
The data from this source is suspect even for its original use, as the cause of death can only be satisfactorily determined by autopsy, which is not routinely carried out. Later, it also found a parallel in the production of league tables for hospitals, which showed 'results' by mortality and morbidity of patients. Publication of such data, without other vital information such as the casemix of hospitals which would show how seriously ill some of the patients were when admitted to hospital - indeed, many would not be expected to live - was mischievous to say the least, fraudulent at worst. It was the cosmological equivalent of using epicycles to explain the movement of the planets.

In 1988 I severed my connection with HDWA, but not my interest in health care policy. As well as having the practical experience of working in a teaching hospital and the Department, and therefore seeing both sides of the health care system coin, I have carried out research for general practice, in private life my spouse is a consultant anaesthetist which gives me another perspective, and from time to time I have the roles of i) a patient and ii) a relative of patients within the system. Thus I view the health care system from many perspectives, and from each there are problems which impinge on the others. For example, while my research has shown the need for cognisance of this fact, it has become increasingly obvious that while lip service is paid to issues such as equity, most policy emanates from the economic perspective. Any policy maker who sees problems solely from this perspective will be forced into posing the wrong questions and will certainly find limited solutions at best and pathological solutions at worst: health care policy and the reforms during the 1980s have had a track record of producing solutions which are next-generational problems. By the end of the 1980s many governments were
looking for solutions, mainly to the perceived problem of cost escalation. The solutions usually involved restructuring of administrative edifices, which in turn added to the costs of management of the health care systems. At the beginning of the 1990s, when academic attention was refocussed on the overall health (or lack of it) in the populations of nation-states, and especially the link between poverty and ill-health, one hoped that practitioners in health care policy and administration might have paid some attention. They ought to have been focusing on health care needs and the best ways in which these needs could be met with the available resources. Such a focus would have caused policy makers to change their mind-set, and to start thinking in terms of patients’ needs, fairness to all stakeholders and the availability of proven treatments. Their attention, however, remained rooted in economic factors, quantitative analysis and the (perceived) need to cut escalating costs. Policy makers had already established in their own minds that this was the most important issue, an unfortunate situation which has led to their inability to ensure that the right questions are raised and the appropriate problems addressed. Thus my agenda is to show the need for a multi-disciplinary perspective which will allow other issues besides the economic to be raised and thereby permit the right questions to be posed.

**Genesis of the Research Question**

Previous research had therefore revealed the critical factors and issues involved in the field of health care and the financing and provision of that care by both government and private agency. After twelve months preliminary reading for this research, which was originally to deal with the introduction of diagnosis related
groupings (DRGs) into the HDWA, it was very clearly apparent that what was required, and what did not seem to be available from my research, was a 'big picture' which could provide the framework for analysis of factors inherent in health care policy. Most of the literature comprises small, 'one-time' snapshots of many of the factors, or discussions of theories, but what is needed is the framework on which to hang all these issues. The outcome of this earlier research convinced me of the need to know how the whole hangs together, over time. In order to succeed in this quest, a 'big picture, broad brush' approach is required, rather than in-depth, narrow focus studies of one or two issues. It is important to show that policy makers must consider factors underpinning both society and health care systems, as well as those issues pertaining to structure and funding of health care systems. These factors include such societal values as equity and compassion, and clinical issues such as autonomy for both patients and clinicians.

At the same time as these outcomes had crystallised, the DRG topic had become a non-viable research proposition. The Western Australian government had decided to introduce DRGs to the HDWA in July 1992, but the timescale for their implementation had slipped too far, and after twelve months reading the literature around the issue, it was obvious that this small area would not yield anything helpful towards a wider analysis. Besides which, the Australian government was spending millions of dollars on talkfests (National Casemix Conferences) to promote this new tool, and other research was progressing on the introduction of DRGs in South Australia and Victoria. The fact that the WA Commissioner of Health denied a University request for access to the HDWA library confirmed my fears on the difficulties of collecting data and to drop the topic of introduction of DRGs to
Western Australia and concentrate my efforts on examining the wider field. My task would be to enunciate those factors and issues which must be considered by health care policy makers. This decision required a complete re-think of how to present such work in a doctoral thesis. It involved reading and analysing a huge literature to understand the arguments from the various perspectives of many issues in health care, rather than the collection of primary data for one in-depth but narrow topic. If this partial shift in focus from primary to secondary data concerns some, then it should be noted that there are many instances where one researcher's primary data has been re-interpreted by another researcher in such a manner, and for certain perspectives in many disciplines, (for example history and literature), there is often no other way. Simon (1992) in discussing the study of the history of science, points to the difficulty, noting that researchers “have viewed it on a more global scale, usually relying on publications as a principal source of data”, and citing the use of diaries, correspondence and laboratory notebooks. One major example is Tycho de Brahe (1546-1601), one of the greatest collectors of primary data on the planets and stars ever known, but who produced neither theory nor prediction with it. His contemporary Johannes Kepler (1571-1630), however, was to use Tycho's data for his “odyssey of thought, which opened up the modern universe”. The use of it as secondary data enabled Kepler to produce a series of planetary laws which prepared the way for Newton (1642-1727), by postulating two dynamic forces to explain the eccentricity of the orbits, ultimately leading the way to our fundamental understanding of the universe. (See Arthur Koestler's The Sleepwalkers: A History of Man's Changing Vision of the Universe. 1959.) Koestler emphasises the need for precise and continuous data: “The Tychonic revolution in astronomical method
consists in the previously unequalled precision and continuity of his observation ... one could almost say that Tycho's work compares with that of earlier astronomers as a cinematographic record with a collection of still photographs."(p.298) While this analogy to photography involves movement, the previous analogy to snapshots above refers to the breadth of the subject matter. Koestler includes the anonymous quotation: "The roads that lead man to knowledge are as wondrous as that knowledge itself." (p.337)

In this work I am taking up the challenge within the policy sciences discipline, described by William Ascher in his inaugural editorial in Policy Sciences (1987, p.3), "to reassert the importance of contextual, interdisciplinary and problem-oriented inquiry." This prestigious journal claims to have the highest citation impact rating of any of the general public policy journals, and such an authoritative clarion call is not to be lightly ignored. Thus this research does not posit and test general laws; rather it conceptualises the problems with the aid of a framework diagram, maps out the relevant factors and evidences those elements of the context which require attention by policy-makers. The aim of this research then, is to investigate the degree of complexity within the health care field by discussing the received wisdom in relation to the factors and issues which ought to inform health care policy. A conceptual diagram of a health care system is offered to provide a framework for the discussion of how the variables are interrelated in policy-making. If this aim is successful, policy makers will be persuaded to thoroughly investigate all relevant factors and allow for them even when driven by the pragmatism of politics into keeping their main focus on economic considerations.
Broad-Brush Research or 'IMRAD' formula

The DRGs topic would have permitted the use of the usual Introduction-Methodology-Results-and-Discussion (IMRAD) formula as used in the physical sciences and often emulated (unthinkingly perhaps) by researchers in the policy sciences. Disquiet has been expressed, even in the 'hard' sciences, about the lowering of the quality of research outputs by the slavish following of such formula-driven approaches. An editorial in The Lancet (1992; 340:345), on the occasion of Karl Popper's 90th birthday, notes in particular "the defects of the I(ntroduction), M(ethods), R(esults) A(nd) D(iscussion) convention that Medawar was so scathing about." In order to paint the big picture with broad-brush research, such narrow, formulaic approaches are inappropriate. Ascher (1986, 1987) focuses on the evolution of the policy sciences from prior to World War II. He notes that his journal has always resisted the impulse to confine 'science' to the search for general covering laws, to narrow the set of relevant variables, and to reject the technique of paying lip service to systems theory by focussing on select fragments of an issue. Rather, argues Ascher, there needs to be a multi-disciplinary approach, with an emphasis on the context and the dynamism of processes. The empirical focus should not be mechanistically determined but should be on human behaviour. In the ideal situation, a policy scientist must examine "how well or how poorly the policy process is operating", and be sensitive "to the effective and formal factors responsible for results" (1986, p.371) Ascher claims that "the scientific objective of analysis is to create a catalogue of behavioural dynamics that make no claim to universality" (1986, p.370), and "given that all aspects of social behaviour interrelate, one cannot do an adequate job of prescription, even on a relatively
narrow issue, without understanding how the whole interconnected system works.”
(1986, p.371) Ascher believes that researchers should be mapping out the potential relevant factors and asking how the variables all fit together, which is what I am attempting to do in the field of health care policy. This type of research is, according to Ascher, scientific in the general sense of pursuing verifiable knowledge rather than the specific (and limiting) sense of searching for general laws.

"The most distinctive feature of the policy sciences approach remains its commitment to broadening rather than narrowing the theories, issues and processes we examine. The policy sciences are problem-oriented, contextual, eclectic and process-sensitive, as nearly every editor of the journal has taken pains to point out....The policy sciences approach ...gives as much emphasis to conditions that block the achievement of valued outcomes as those that ensure it.”
(1987, p.4, 7)

Such reasoning from eminent practitioners in the policy sciences reinforced my confidence in the decision to use broad-brush methods to pursue what I recognised as an important and urgent issue in health care policy.
1. The Research Question
The objective of this research is to analyse the non-economic issues and factors involved in the financing and provision of health care, and to make an argument for their inclusion in the policy making process, rather than allowing economic considerations to eclipse them. Many of the assumptions underlying health care issues appear to be taken for granted, when in fact they ought to be examined for their relevance to today’s problems. Of major importance is the moral dimension in policies dealing with human health and welfare, which is clearly either forgotten or is afforded too little consideration in policy making. (See, for example, Etzioni 1988; Annals of Internal Medicine (Editorial) 1990; Badgley 1991; Clarke & Stainsby 1991; Haas 1992; Hurowitz 1993; Achenbaum 1994; Brody et.al. 1994; Donnison 1994; Fleischman 1994) This is particularly relevant to the issue of rationing of health care in publicly provided health care systems, which while it has always been quietly practised by clinicians, is now required to be overt because demand for health care has outstripped available resources. Perhaps there is too much complexity, confusion and change occurring at too fast a pace in the health care field for policy makers to assimilate and deal with problems adequately. It will be argued that policy makers commonly have a unidirectional economic perspective in both policy making and in health care system reform directives, a situation which leaves issues such as health status of the population and of equity in resource allocation to political rhetoric, while in practice, policies deal with the issue of cost reduction. The substance of the argument comes from the analysis of
the literature on the broader issues affecting health care policy, such as concepts of social justice and ethics of resource allocation including access to care, which ought to have a strong influence on policies dealing with those narrower issues concerning the actual mechanisms of funding and providing health care systems. We need to understand what values are informing the narrower issues, such as public versus private finance, health insurance, remuneration systems (fee-for-service, salary and other packages), management procedures and processes in departments or ministries of health and hospitals, manpower planning, facilities development and maintenance, organisation of general (family) practice and medical specialties, and education and training of professionals. At the practitioner level are the important issues of autonomy, both clinical and patient, and the patient/practitioner relationship, which has been in a period of flux of late due to the rise of consumerism, itself a concept of the 'new public management' and market economics which has seen 'the patient' become 'the client' or 'the consumer of health care'. Then there are the issues of accountability, quality of care, and the lack of quality data and communication pathways, all of which impact on the preceding issues. Some issues are elements of macro, or national, health care policy and some of them occur at meso, or institutional, level. Others affect policy making at the micro level, where the interaction between individual patients and their medical practitioners takes place.

The field of health care policy is extremely complex, with evidence of confusion at all levels. (Barker & Peters 1993) Compounding this situation is the occurrence of continual social and technological change, producing what the Editor of Health Care Analysis (Seedhouse 1994) has termed 'theoretical incoherence'. It
is not only the quantity of change which is important; it is the pace of change that is so hard to assimilate. Technical advances have left behind the moral discussions in many areas of medicine. This environment causes moral dilemmas of enormous complexity, with which policy makers should not have to deal by themselves; this is clearly a problem for society as a whole. Canada is one country that has attempted to obtain societal input by providing a forum for discussion of provision of health care, but most countries have yet to see the need. Problems at the broadest level include the rationing of services. If services are to be cut, and there is much evidence of this happening already, we need to ask who should suffer the withdrawal of free health services. Should those with irresponsible lifestyles and who pursue dangerous pastimes, such as motor racing or mountain climbing, or those who eat and drink to excess (or too little!) and those who smoke be denied free care before services such as accident and emergency departments are closed down, an action which deprives whole communities of essential health care service. Or perhaps the young should have precedence over the old in terms of resource allocation, because the young will gain more benefit than someone who might die very soon. Or perhaps certain programs, such as those dealing with infertility, or affecting only a few people, should be withdrawn from public provision. Then again, perhaps by limiting the number of clinical providers, or setting limits on their earnings, resources may be stretched further. All these solutions have been tried, but the underlying moral assumptions in these issues need public discussion and clarification. At the clinical level, the moral dilemmas are very clear to those individuals involved. For example, babies of 22 weeks gestation may be legally aborted, underlining just how underdeveloped they are, as
they would normally have another four months in the womb. But technology has advanced to the point where in certain hospitals there is the expertise and technology available to give such underdeveloped babies born preterm at 22 weeks a chance of viability. Some parents thus have the opportunity to take home a child after some six months of very intensive and expensive (up to 100,000 pounds sterling in the UK) specialist hospital care, while other parents are told that there is nothing that can be done to save their child born far too early. In the 1960s in the UK, only 15% of all babies born before 28 weeks gestation survived, and even those born at 28 weeks had a mortality rate of between 70% and 80%. Now 28-week babies have a 90% survival rate, of whom 90% have no handicaps. Should, indeed is it possible for, health care standards to be the same everywhere, or is it a case of luck of the draw, defined by geography and availability of specialist medical personnel and well-endowed hospitals? This of course applies to publicly provided health care; patients with insurance cover or the ability to pay outright can purchase the standard of care required. In the case of preterm infants, however, no amount of resources can save those born before 22 weeks gestation, because body organs are too immature and current technology is not far enough advanced. But those premature babies born in the grey area of 22 to 24 weeks gestation may be saved if there is the money to pay for the service. Another example currently under discussion is euthanasia. This topic is producing moral dilemmas for clinicians and families of terminally ill patients, many of whom argue that people should have the right to determine when they die, with clinical help if necessary. The same dilemmas are occurring for very many treatments which are being withheld by health care institutions because of budgetary restraints. These issues are real, they
are causing pain and suffering to patients and misery to clinicians and families, and they are being placed second in importance to the issues of reducing costs and obtaining ‘value for money’ by politicians, policy makers and decision takers in health care systems. Obviously health care systems utilising public taxes must be designed to a finite budget, but these moral dilemmas need to be addressed with compassion and some intelligence for searching out new ways to fund and allocate resources. There is no sense in denying people the right to purchase private health care if they have the private resources, simply because of a misplaced fear of a ‘two-tiered’ (and therefore somehow ‘inequitable’) system as certain parties argue in the UK and Australia. Nor should the purchase of private health insurance be discouraged because of a government’s ideological stance of insisting on the myth of ‘free health care for all’, as did the federal government in Australia during the 1980s and early 1990s. Health care policy is based on values, (Priester 1992, Blendon et. al. 1994), but the value system(s) remains unacknowledged. The values placed on such factors as the cost of health care, the quality of health care and access to that care must be brought out into the open, and policy makers must declare which values they are using to justify their decisions. These issues are addressed in a later chapter dealing with concepts of social justice.

Another area that policy makers must open up for debate concerns definitional problems that arise when different meanings are attributed by various participants in health care to certain key terms such as ‘health’, ‘health status’ and ‘health services’. This type of problem adds to the confusion. Definitional problems are also caused by the existence of different models for viewing the same problem, such as ‘health care need’. A good example concerns the ways in which
policy makers view the needs of the aged in society. Wilson (1991) puts forward various models, and shows how the policy made will differ dramatically according to the assumptions behind the models. For example, one model assumes that old people require more and more care as they age. Another model assumes that the aged will require help of varying degrees of intensity at several times during a period of years. These two models provide vastly different policies for aged care in terms of resources required, not to mention the way in which patients are treated as persons who must be permitted to retain their dignity and self-esteem. Other definitional problems include ‘health care demand’, whether a patient can be a ‘consumer’ of health care as that term is understood for market goods and services, what ‘prevention’ and ‘new public health’ mean, and the issue of accountability. Such issues are discussed in Chapter 2.

Like everyone else, policy makers (politicians and bureaucrats) hold assumptions of how society is and ought to be, and on all the issues affecting health care. But the assumptions of policy makers, often held at a subconscious level, are infrequently debated and will affect the content of policies for the funding and provision of health care, thereby affecting everyone in society. Each health care system is a product of its society and reflects the political, social and economic realities of a society’s past as well as its present day needs and concerns. The concentration of politicians and bureaucrats on the economic realities over the last decade and possibly longer, has resulted, logically, in a search for ways and means to stop the escalation of health care costs, which has led to attempts to ration resources which in turn has led to inequities, even in the face of political rhetoric for equity of access. Economics, as a ‘scientific’ discipline, offers to health care
policy makers what must be tantalising, measurable ‘evidence’, as opposed to the comparatively intangible and ethereal concepts of equity, fairness or justice. But as Medawar (1991, p12) points out, while there are very few modern problems to which scientific evidence is irrelevant, there can be very few problems where scientific evidence is all the evidence you need. (Italics added) Unfortunately, the pre-eminence of economic theory today is such that policy makers either underestimate the need for other issues to be debated, or are too pressed for time to assimilate a very complicated area. Ultimately, perhaps, they are over-ridden by political pragmatism. Yet the moral climate in which the economy and society function was an important theme in Adam Smith’s “The Wealth of Nations”, with an important role of the state being to assume powers to support the moral framework as and when necessary. As Paul Omerod (1994, p.14) points out:

“In sharp contrast, modern economics views the economy as something which can be analysed in isolation. There are few greater insults in an orthodox economist’s vocabulary than to describe someone as a sociologist. The institutional setting, the historical experience and the overall framework of behaviour are ruthlessly excluded from contemporary economic theory.”

It will be shown that the reforms introduced in health care systems to achieve a reduction in cost escalation have concentrated on the restructuring of those systems, to the detriment of concepts of fairness and justice, and at no discernible benefit to the health status of either populations or individuals. It will be argued that it is precisely the need for those aspects - the institutional setting, the historical experience and the overall framework of behaviour - to be included in the policy making process. Furthermore, because of the narrow focus of the reforms, many of the new policies have caused problems in the wider society. One example suffices here. The de-institutionalisation of mental hospital patients
without adequate alternative programs for housing and follow-up health care caused a degree of homelessness and higher morbidity (and crime) in many countries. This policy outcome forced the expenditure of more resources from other sections of the welfare budget, and caused the dislocation of many patients to the detriment of their health and well-being. Where higher mortality occurred, and assuming it was an unintended consequence, it lessened the economic burden as the dead can't claim welfare, but it surely added to the moral burden of those who created the situation.

Health care system reforms in five OECD countries - Australia, United Kingdom (UK), New Zealand (NZ), Canada and the United States of America (USA) - are used throughout this discourse as examples of problems, attempted solutions and results of reform. Comparative studies of health care policy and health care systems in different countries show how the differences and similarities in policy and management will stem from the universalistic factors, such as the art and science of the practice of medicine and scientific technique which are broadly common to all countries, and to the particularistic factors inherent in different cultures and societies. (Field 1989, Roemer 1985) Such information can aid understanding of changes in any particular system, and may provide input to further theory development and policy-making. It can also alert politicians to the fact that certain changes will not be possible, as was the case for President Clinton's health care reforms. It certainly provides evidence for the limits of the degree to which policies and organisational features can be transferred from one country to another without due recognition of the particularistic variables. The five countries were chosen because their social, political and economic systems, while similar in many
respects, have enough substantive differences to have produced health care systems differing in major aspects. In addition, the ‘exceptionalism’ of the USA provides a useful foil for the other four countries. For example, the USA spends more than any other Western country on health care, has approximately 40 million people without access to health care or health insurance and has the worst health status outcomes (OECD 1990). Schieber et al (1994) found “little quantifiable evidence of value for money or equity in terms of health system performance” in the USA.

The other four countries have health care systems which provide universal access to ‘free’ or minimal-cost health care at point of receipt to all their citizens, have much better control over the total costs of funding the provision of health care and have similar health status outcomes, although the UK has slightly worse outcomes than the other three countries probably because it also has the lowest percentage of GNP allocated to the health budget. In this respect, Klein (1983) noted that the UK’s National Health System (NHS) has ‘universalised the adequate’, by sacrificing rapid diffusion of high technology and highly specialised services and by emphasising the routine and less expensive treatments. (Wilsford 1995, p.597)

The issues outlined above and their underlying assumptions are examined in the following chapters. The work proceeds from the view that health care policies have focused too narrowly on budgetary concerns, resulting in health care systems whose bureaucrats are more concerned with controlling the costs of health care than they are with either the health status of the population or the equitable access to health care for their constituents as individual patients. Policy makers have relied too much on economic factors while ignoring the ethical and moral dimensions of questions related to health care. The political rhetoric refers to
`equitable systems giving value for money`, while the reality focuses on costs of care not on the medical needs of patients. In their search for formulae grounded in economic theory, health economists have moved the focus in health care at the micro level from medicine to finance, so that the health care of individuals has been removed from the ambit of clinical autonomy into that of the cost accountant, a result detrimental to both the treatment outcome of the individual and the equity and fairness of the health care system. It is argued that a broader focus, encompassing other perspectives, would highlight issues of equity, accountability and justice which policy makers must take into account to guard against the outcomes caused by the narrow focus of an economic perspective. Until policy makers consciously address the issues outlined, and ensure the coherent interconnections of these issues with the economic factors, the reforms to health care systems cannot be expected to bring about the changes which are requested and (irrationally) expected of them, but will continue to make piecemeal changes to delivery systems which are inequitable and produce inferior health care.

2. **Analysis of Health Care Policy**

The complexity of this field requires some preliminary discussion to set the scene for more in-depth analysis in later chapters. This section deals with the issues and participants involved, the cognitive difficulties of policy makers in this field, and the levels of analysis, herein defined as macro, meso and micro. The opportunity is taken here to examine in detail the problems of data collection within the health care field.

2.1. **Issues & Participants**

Research on social issues is always `messy`, and as Rein & Schon (1993) point out, some policy controversies

"cannot be understood in terms of the familiar separation of questions of value from questions of fact, for the participants construct the problems of their
problematic policy solutions through frames in which facts, values, theories and interests are integrated. Given the multiple social realities created by conflicting frames, the participants disagree both with one another and also about the nature of their disagreements.

This quotation accurately depicts the health care policy field, and throws into relief the real problem: theoretical incoherence and resultant confusion of objectives for reforms to systems. Figure 1. depicts the participants, herein named ‘stakeholders’ and their political agendas, from which can be seen the multiple ‘social realities’ existing in this arena.

<table>
<thead>
<tr>
<th>Stakeholders</th>
<th>and their Agendas</th>
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<tbody>
<tr>
<td>Economists</td>
<td>Want to utilise economic theories, in particular market theories to promote budget cuts and cost saving techniques e.g DRGs, PPOs. This has led to political hijacking of technical solutions e.g QALYs/HYEs</td>
</tr>
<tr>
<td>Clinicians</td>
<td>Want to keep clinical autonomy of the physician-patient relationship. As principal/agent, want autonomy to spend resources. Resistance to cost cutting, fearful of loss of quality of care. Focus on outcomes, with resistance to ‘cook-book’ practice</td>
</tr>
<tr>
<td>Managers</td>
<td>Keen to clip clinical autonomy, require evidence-based medical practice and use of clinical guidelines, with accountability and audit trails. Led to new organisational forms e.g. HMOs; Managed Care</td>
</tr>
<tr>
<td>Politicians</td>
<td>Want value for money; stop wastage. Shift responsibilities for rationing onto clinicians and managers. Will interfere in the rationing process when constituents complain.</td>
</tr>
<tr>
<td>Patients</td>
<td>Want best quality treatment to be available when required, and if not free, at least reasonable cost. Demand patients’ rights but ignore responsibilities. (Somebody else’s fault - why me?)</td>
</tr>
<tr>
<td>Tax payers</td>
<td>Justification for health care: social good, as a human right, or by ‘just desert’. Social &amp; cultural elements which feed political process. The reason for justification will affect type of health care system structure, funding, provision</td>
</tr>
</tbody>
</table>

**Figure 1. Stakeholders in Health Care Systems and Their Areas of Policy Concern**

To further confuse the issue, individuals within these groups of stakeholders can belong to several of the categories simultaneously. Individuals in each of the
categories of professional interests - clinicians, politicians, economists, managers are usually also taxpayers. They may be patients as well from time to time. They can also be re-classified into recipients, or users, of health care (as individual patients, or members of populations), providers of health care (medical and allied health practitioners; hospitals and institutions) and planners and funders of health care (public and private sector planners, funders and administrators). When this overlapping of roles occurs there may well be conflicting priorities and values in competition for recognition, which may induce individuals to re-evaluate their own stance in health care matters. Each group will have a different frame of reference by which they relate to policy and to the management of the health care systems and programs which emanate from policy decisions. In the broader societal context, resources required for the provision of health care must be balanced against the needs in other policy areas such as education, housing and welfare. Thus it is that Americans will, on the one hand, vote for their government(s) to introduce policies to help the 40 million people without health care cover, but on the other hand, will refuse to pay higher taxes, condone the redistribution of wealth or alter the status quo of the pharmaceutical and insurance industries, which would permit such policies to take effect. Opinion polls clearly show that Americans would like everyone to have health care cover, but they don’t want their own cover lessened, or shared, in order for that objective to be realised. Health care policy itself is aptly described by Easton’s note that “policy consists of a web of decisions and actions that allocate...values”. (quoted in Ham & Hill 1984, p.11) It is this issue of values that lies at the heart of problems in health care systems, an issue with which reformers are struggling in their efforts to change both structure and
function of the systems, and to enhance the outcomes of policies within those systems. The early reforms tried to enhance the outcomes of efficiency and value for money, while some reformers in the last two or three years have recognised that the focus on outcomes ought to be changed to encompass betterment of the population's health status, quality of care and consumer advocacy. In Australia, for example, the National Health Strategy (a federal Labor government initiative) concluded that it is important to shift the emphasis from funding and providing health services and institutions to providing care that improves health. (Hall 1996) In the UK there has been a refocussing on the relationship between poverty and ill health. One connecting mechanism for policy makers is the research of academics and of government committees in fields other than health economics. As yet, however, there is little tangible evidence of policy which takes either source into account. As Klein (1990, p.501) has noted:

"successive governments ... have seemingly undervalued, under-financed and under-used the capacity of the research community to inform policy-making".

The problems of the issue of values is explored more fully in Chapter 5, which deals with problems of social justice and the issue of rationing of resources. The rationing of health services is the logical outcome of the failure to address perspectives other than the economic in reforms to health care systems.

2.2 Cognitive Difficulties and Uncertainty

The one factor in health care that remains constant is uncertainty. Barker and Peters (1993) have recognised at least six levels of cognitive difficulty in the public policy field of health care (Figure 2), which places perhaps more constraints on policy makers in this area than any other policy area. In some
relationships are complex, and the reasons for the variance found between different populations and sub-populations can only be surmised.

<table>
<thead>
<tr>
<th>Figure 2. Policy Difficulties in Health Care</th>
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<tbody>
<tr>
<td><strong>Policy Field’s Character</strong></td>
</tr>
<tr>
<td>(1) <em>Elaborate detail</em></td>
</tr>
<tr>
<td>(ii) <em>Complexity</em></td>
</tr>
<tr>
<td>(iii) <em>Technical difficulty</em>, but - like (i) &amp; (ii) - amenable to non-expert study</td>
</tr>
<tr>
<td>(iv) <em>Technical difficulty</em>, which those with expert training (e.g. epidemiological data, probabilistic mathematics, statistics, analysis of future health care needs; economics, medicine) can appreciate and judge</td>
</tr>
<tr>
<td>(v) <em>Technical difficulty</em> bordering on the scientifically unknown, and with rival &amp; controversial scientific views on offer</td>
</tr>
<tr>
<td>(vi) <em>Scientifically unknown</em>: no rival claims from experts</td>
</tr>
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*Six levels of cognitive difficulty in the public policy fields.*

There is a truism, often repeated (Braithwaite 1995), that societies may have health care systems with any two out of these three attributes:

* a good (quality) system
* a quick system
* a cheap system
Thus we may have a good, cheap system in which people will have to wait for service; we may have a good, quick system, which will be very expensive; or we may have a quick, cheap system, in which the quality of care will be poor. Policy-making in health care is therefore a complex process of balancing competing needs of different interests and carefully evaluating the various trade-offs and their implications. The trade-offs, which are usually part of the root cause of problems in health care systems and therefore the object of various reform strategies, are between costs of health care and equity, efficiency and equity, and quality and efficiency. Policy-makers in health care now try to link the inputs to the system to outcomes, instead of outputs, in the quest to find out how costs and efficiencies in health care relate to the effectiveness and equity of results. Other conflicts include the types of services such as acute care versus preventative and rehabilitative care systems, and the managers of institutions providing the care must frequently adjust relationships between different elements of those systems - such as hospital funding versus community care funding. Many countries, with systems which differ in many aspects, are instituting the same strategies in order to ‘reform’ aspects of their own system so that the proper balance is obtained. There appears to be a worldwide trend, over the last decade and half, to search in the same direction for better ways to provide services and to curtail the growth in costs. (Frenk 1994, Hsiao 1992, OECD 1992) But this has been likened to the search for the Holy Grail (Maynard & Hutton 1992). This once again reflects the cognitive complexity of the field, as policy makers appear content to follow each other in their quest for better systems, even though each system exhibits different structures and problems. At the national policy level, there is uncertainty as to how much
should be spent on health care and where resources should best be placed, whether or not a two-tier health care system ought to be permitted to develop, how much private funding is acceptable, and how much regulation is required by the profit-factor. Perhaps the most worrying issue is the way in which health care resources will be rationed. The uncertainty at this level has been exacerbated by what Iglehart (1986a, p.204) has termed

"a disconcerting tendency by all Western governments to nurture - as a political good - the availability of medical services without a concomitant willingness to inform citizens that substantial costs are attached to the benefits that ensue."

At the organisational level, there is uncertainty as to the best way to integrate the various cultures entailed in competitiveness on the one hand and collegiate cooperation on the other, as managers and medical personnel try to come to grips with institutional change. Uncertainty causes vacillation between regionalisation, devolution, centralisation and decentralisation, and produces rifts between groups who had previously enjoyed a balanced power structure. Exponents of the 'new public management' require managers in health care institutions (notably UK Trust hospitals and NZ Crown Health Enterprises (CHEs)) to be entrepreneurial, then wonder why some managers validate public choice theory by practicing self-interest and profiting by their decisions. In the UK there have been several scandals where Health Trust managers have maximised their own benefit before the public's. The BMJ (23 March 1996 p.729) reported the case of four senior health service managers in Yorkshire who misapplied some 500,000 pounds sterling of NHS funds, including about 150,000 pounds sterling to their own benefit, according to the parliamentary spending watchdog, the National Audit Office.
They were accused of “behaving in a manner unacceptable in a public servant”, and “imprudent and foolish”. One of them, however, said that he was unrepentant in adopting an approach that was in the best interests of the NHS, even if the rules were bent or broken in the process.

There is an acknowledged need for links between the various levels of service - primary, secondary and tertiary - and between community care requirements for aged care and chronic care and the more immediately satisfiable acute care, but very few strategies have been put forward to deal with this issue. The medical profession at the micro level has always had to accommodate uncertainty - hence the truism that the practice of medicine is as much an art as it is a science. [Osler remarked that medicine is a science of uncertainty and an art of probability.] Where once uncertainty related to the scientific realms as to why some treatment worked, it now encompasses uncertainty as to whether a treatment is of sufficient benefit to justify its use. As Maynard & Bloor (1995, p.251) observe, the aura of science as an attribute of medicine is well established, but is unsubstantiated. The certainty of medical paternalism has been eroded, replaced by the uncertainty of the status of the doctor-patient relationship, as clinical autonomy, patient autonomy, patients' rights charters and consumerism vie for priority. The very concept of the principle of doctor as agent for the patient is under scrutiny, with new forms of organisational collectivity (such as managed care and health maintenance organisations) replacing the one-to-one nature of the medical consultation. Clinicians must accept that confusion across society is likely to increase over the next few decades in the face of an accelerating information explosion. Complex intellectual analyses of ‘quality’ (Donabedian 1978, 1982,
1996; Maxwell 1984) risk leaving many health care workers uncertain and worried that their working lives are being diverted towards the pursuit of a chimera called ‘quality’ that has little to do with patients’ real needs (Taylor 1996). Carr-Hill (1994) notes it is increasingly assumed that an emphasis upon technical quality will automatically lead to the provision of an effective and efficient service, which is also automatically the most equitable. But Donabedian’s components of quality focus almost entirely on the scientific and technical ability of the health care system, and the humanity with which health care is distributed, and as Carr-Hill observes,

“Although these are clearly important, such a definition could lead to a health service that is ineffective, inequitable, inefficient and inadequate to meet the needs of a population.” Carr-Hill (1994, p.1189)

As well as these problems, the collection, analysis and distribution of data, which may give direction and rational choice to policy makers, cause additional difficulties which are addressed below.

2.3 **Data Difficulties**

Little attempt has been made to collect data on the underlying assumptions and values in policies, as attitudes and personal opinions, even though they directly influence policy, are deemed ‘soft’ and not worth the effort entailed. It is economic data that is assiduously collected, yet there are immense problems associated with the collection and analysis of this information. The OECD has a major interest in health care reform and research in the funding of health care systems, but OECD research has an underlying bias towards econometrics, and therefore concentrates on the allocative and technical efficiencies of health care systems. It also has inherent problems associated with collecting *comparative* data,
as Poullier (1990) comments in his description of the *OECD Health Data File (24 countries)* (OECD 1990, pp 119-126). Poullier notes that while reliable information is essential for rational policy-making, much of health policy is made with only partial information. For example, the division between private and public shares in the financing of health care is based on hazy concepts and the health accounting framework is typically fragmentary. The dearth of outcome indicators hampers considerably the analyses of the overall performance of health systems as well as the effects of particular policy interventions. Although the simple availability of reliable information does not necessarily lead to appropriate clinical or service delivery decisions, in most areas of public policy, reliable information is an essential ingredient in improving the policy-making process. The collection of data is mostly undertaken at national level, but is often used at an international level for comparative purposes. The OECD undertook a process of re-evaluation of accepted health information and accounting standards in many countries, and the statistical work undertaken during the 1980s is considered an essential supplement to the work of the World Health Organisation (WHO) and its objective of “Health for all by the Year 2000”.

Three main approaches to compiling and processing official data at the international level are identified by Poullier (1990, p.119):

An international (or related) agency fully finances a survey and thus controls its variables. Identical questions, common concepts and definitions and single processing are employed.

Agencies from various countries determine that an area is worth a co-operative effort, work together to harmonise concepts and definitions, and supply the corresponding time series to a single compilation unit.

An analyst attempts to ‘massage’ data from various countries, using as closely comparable units as can be obtained from the information readily accessible.
The first approach is the surest way to attain fuller cross-national comparability. It is rarely used, however, because it is the costliest. The second is the most classic method but takes years to implement because numerous meetings are necessary to agree on boundaries, classification principles, accounting units, compilation lead-times, etc. The third approach is the least precise because judgments are made by the compiler only. With this approach, however, several years are saved and costly meetings avoided. The OECD Health Data File belongs in the third group, and, while having the weaknesses of this approach, its strength lies in the fact that there is no better alternative. An international compilation cannot be superior to its national constituent parts. Because data originate from several sources in each country, and those sources are not necessarily consistent with one another, the Health Data File is fraught with international inconsistencies, gaps in coverage and definitional heterogeneity. However, consensus is that in international health comparisons, the trade-off of precision for timely accessibility of the data is a difficult but necessary one. It is as well to remember that the OECD Health Data File is designed to facilitate the identification of trends rather than detailed policy prescriptions.

2.3.1 Some ‘Boundary’ Problems

In most countries, health care is monitored by a ministry of health, but a number of ancillary activities may be treated differently by agencies within various countries. Such activities include armed forces health services, school health services, industrial medicine, family planning centres, nursing homes and the like. Some countries include nursing home beds within the category of ‘in-patient’, whereas most do not. Ambulatory care (outpatient clinics and doctors’ surgery-based
medicine) provide similar boundary problems. Chiropractors are licensed in some countries but not others. The statistical subsystems (e.g. expenditure and manpower data) of different agencies have heterogeneous definitions, with detailed, underlying series inaccessible in the published sources. There is a lack of consistency within a country's own definitions. The most common pitfall consists in using parameters with identical names as if they were comparable (Przeworski & Teune 1970). Although similar terms are used, the meanings may differ because they may not be based on formal prior agreement on concepts, definitions, estimating methodologies, etc. In a comparative international data base, the problems encountered at the national level are magnified. There are many other areas of contention, as the following sections demonstrate:

i. Pharmaceuticals
Measuring the use of pharmaceuticals relies on the apparent-consumption approach established on the basis of production data minus export plus imports plus net changes in inventories. But this does not measure actual consumption - there may be many drugs sold but never consumed, as evidenced in the containers of medicine found in many home bathroom cabinets.

ii. Hospital records
Distinctions between admissions and readmissions are often not made, yet this is an important variable in considering whether the pressure to lower the length of hospital stay (as brought about by the introduction of DRG/Casemix policies) leads to the early discharge of patients who later require further episodes of hospitalisation.

iii. Cause of Death information
The medical evidence of death records can rest on cultural differences. One OECD country may record little mortality from bronchitis, simply because this classification is not used in its medical schools. Deaths from 'other respiratory diseases' will be correspondingly more frequent in this country. International comparisons may thus require the aggregation of two or more subcategories.

2.3.2 Other Areas of Contention

The following seven major categories of statistical data share the problems outlined above as well as those inherent in the particular subject, and are condensed from Poullier (1990, pp 121-126) These show that economic data is not as valid and reliable as many health economists like to believe.

i. National Accounting Concept

The expenditure on health care tries to identify all underlying elements, and attempts to adhere to rigorous economic classification principles. But there are grey areas, for example, some expenditures may be classified differently in various countries - publicly funded medical research and development can be attributed to science support outlays, not health. Prison health services may be attributed to justice department outlays, not health. Depreciation on hospital buildings may be counted in one country and not in another.

ii. Prices and Incomes

To obtain a measure of real resources devoted to health care across countries or over time requires controlling for price trends. Have the resources devoted to health care really decreased in some countries, or have they merely stabilised, as
exhibited by the simple ratio of total health expenditure to GDP or GNP? The
answers rest on the evidence from data regarding prices. The methods of
elaboration of the implicit price indexes of GDP and GNP are well documented:
those of the numerator (health care consumption) are less so.

iii. Social protection

The level of social protection (i.e. public coverage for health care) is essential to
understanding the private-public mix variations in the financing of health care.
The indicators of public coverage constitute an entitlement index. The measure is
straightforward in countries with universal access to publicly funded health
services, but for the others, an interpretation is required of institutions and
regulations which at times are not fully detailed. No OECD country publishes an
index of cost-sharing, but trends can be seen in the changes in liberalisation of
certain services, the substitution of programs for ‘older’ killer diseases such as
polio or tuberculosis, with those for AIDS, and the implementation of treatment
options as medical technology advances. In the opposite direction, trends of
increased patient costs for pharmaceuticals can be seen as new medicines force
governments to reduce drug benefits.

iv. Medical care use and personnel

The OECD Health Data File has been designed as a measure of usage as well as a
measure of actual inputs; i.e. usage of beds as well as number of beds. Numbers of
licensed physicians may include retired or inactive personnel, which would
invalidate assumptions about usage and manpower ratios. Definitional differences
contribute to the inter-country differences in pharmaceutical consumption. Are
hospital outpatient medicines included or not? Are physicians permitted to dispense medicine? Is a prescription counted as one unit, or are the items within a prescription each counted as one unit? Should 6 boxes of beta-blockers prescribed for a hypertensive patient over 6 months be entered as one prescription or six? In compiling international data, the necessary details to ensure consistent treatment across countries is lacking.

v. Medical practice variations

Medicine is widely held to be a science, but many medical decisions do not rely on a strong scientific background, simply because such a foundation has yet to be fully explored, developed and tested. There is much clinical uncertainty, leading to medical practice variations. (Waitzkin & Hubbell 1992; Wennberg 1990, 1996; Westert et al 1993) When comparing rates for health care practices on a cross-national basis, many possible reasons for observed differences must be examined. There can be legitimate causes for variation, such as prevailing rates of illness, age and gender characteristics, or there may be artifactual reasons caused by statistical methodologies. The determination of medical efficacy is extremely difficult.

"The consequence of doing one rather than another intervention for a given disease state is, in such circumstances, imprecisely understood by anyone, so clinicians must rely on their own best judgments and some medical consensus where it exists." (OECD 1990, p.21. McPherson)

Many countries don’t collect the necessary data, others use variations of classifications, such as the 8th Revision or 9th Revision of the International Classification of Disease (ICD), which means direct comparisons cannot be made as these two revisions differ. Data for Australia related only to New South Wales, until the advent of the Australian Institute of Health (now the Australian Institute of Health and Welfare), set up in 1987 to act as a national data collector. The data
for the UK come from a one-tenth sample based on a British classification
developed by the Office of Population and Census. The average length-of-stay
figures for New Zealand are weighted for private and public institutions. There are
conceptual differences related to the definitions of personnel per bed, and
definitions of nurses vary.

vi. Health Status Indicators

There are few appropriate indicators to allow countries to adequately monitor the
outputs of health care systems. International organisations have limited their data
to a small set of ‘standard’ indicators. Life expectancy tables, infant and perinatal
mortality rates and morbidity and mortality statistics may reflect advances in
medical knowledge and the diffusion of certain medical procedures, but they do not
lend themselves to the measurement of the outcome of public health programs and
policy. Other socio-economic factors such as unemployment, housing and
sanitation levels are as important to health status outcome as are medical
treatments and public health programs.

vii. Demographic and economic background

International comparisons require ratios or the use of a common numeraire to deal
with differences in population sizes and currency units. The principal source for
general economic and demographic background data in the OECD compendium is
the first volume of National Accounts 1960-1987 published in 1989, which reflect
guidelines that have been gradually established by statisticians in an
‘harmonisation process’ started in the early 1950s.

"Differences observed in, for example, hospital beds per 1,000 population
or pharmaceutical outlays per person when using national sources or the OECD
data are not necessarily attributable to the numerator but may be caused by the denominator. Although an effort has been made to ‘massage’ the numerator entries, the harmonization process of working from details to publish the most comparable aggregates is still in its infancy, whereas the body of principles on which the denominators are based is considerable”. (Poullier 1990 p.125)

The collection of data by highly experienced OECD researchers with huge resources at their disposal is fraught with inaccuracies, and the best that can be hoped for is to provide broad comparisons between countries. The differences thrown up by such comparison, however, do give scope for asking questions about the basics of health care systems, such as global budgeting, insurance and, at a lower level, the types of remuneration of health care professionals. These data cannot address the important aspects of fairness and justice, the accountability of all participants and the morality and ethics of the resource allocation process. In other words, OECD data deals with statistics, not values, which is now the most important aspect for health care policy makers. It is with values that this thesis is most concerned, and the gathering of information presents the problem of utilising the work of others, which is often seen as secondary data and therefore somehow perceived as second-rate or inferior data. The kind and sources of data utilised in this thesis require a particularly strong defence, as the work of many experts in such fields as social justice and ethics in clinical medical work is germane to the argument that these issues must begin to inform health care policy. The opinions of such experts may be obtained from their writings, which in many cases qualify as primary sources. Other authors discuss the views of these various experts, and their written opinions also might be classified as primary sources. The comparative data on the countries’ health care systems is obtained from OECD sources, which, given the problems outlined above, is not above suspicion nor does it cast any light
on assumptions, values, the history of institutions or any of the other intangibles which inform (however unconsciously) health care policy and the organisation of health care systems. The 'secondary' sources of journal articles in this thesis are far more likely to contain uncontaminated data than the OECD data, and are the data required for an investigation into the complexity of health care policy.

2.4. Levels of Analysis

Ham & Hill (1984), in their study of the policy process in the modern capitalist state, indicated the necessity to focus on different levels of analysis, and demonstrated how the interaction between levels is particularly significant and problematic. They utilise the micro-level of decision making within organisations, the middle-range analysis of policy formulation, and the macro level analysis of political systems. The analysis undertaken and described in the following chapters also utilises these levels of decision- and policy-making but in a different context. The macro-level deals with policy at the political system level, while the middle-range, or meso level, deals with policy at the institutional level (political institutions, bureaucracy, health care facilities), and the micro-level analysis occurs at the patient/consumer and provider interface. This method allows for the inclusion of those aspects - the institutional setting, the historical experience and the overall framework of behaviour - deemed necessary for health care policy making. Jenkins (1978) sees the choice of level on which the analyst operates, and the linking of levels, as methodological problems standing in the way of the development of a theoretical perspective for policy analysis. He also contends that "much that passes for 'explanation' in the policy world is inadequate because of its failure to explore the micro-structure of the political system." The necessity to
also consider the breadth of the problem is recognised by Wildavsky (1979, p.15) who argues that "content cannot be determined by disciplinary boundaries but by whatever appears appropriate to the circumstances of the time and the nature of the problem." Both these viewpoints reflect the problems of health care policy, which requires depth in the analysis of the issues involved in the disputes between costs of care, quality of care and access to care and the breadth of analysis to include all the issues which underlie the ‘big picture’ of health care funding and provision, and which may be categorised as the difficult ‘morality’ problems of fairness, justice and value systems. Figure 3 below shows the three policy levels and the major issues of conflict within them, and Figures 4, 5 and 6 following show the expanded issues of concern at each of the policy levels. Thus the macro issue of conflict in Figure 3 ‘Health versus other needs’, is expanded to another issue which requires greater analysis; that greater expenditure on health care systems does not necessarily give better health status. Policy makers have to know the opportunity costs of allocating resources to health care systems as opposed to housing or some other area which may provide healthier living conditions. Figure 4 shows the issues of concern at the macro policy level. (This figure relates to Box 5 in the conceptual diagram (Diagram 1) to be found in the next section)
Figure 3. Issues of Conflict at Three Policy Levels

<table>
<thead>
<tr>
<th>Policy Level</th>
<th>Issues of Conflict</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Macro level:</strong></td>
<td>health versus other needs (e.g. education)</td>
</tr>
<tr>
<td>Equity-(\textit{political})</td>
<td>- health costs as % GNP</td>
</tr>
<tr>
<td></td>
<td>- federal/central versus state/province/local</td>
</tr>
<tr>
<td></td>
<td>- cost sharing</td>
</tr>
<tr>
<td></td>
<td>- program provisions</td>
</tr>
<tr>
<td><strong>Meso level:</strong></td>
<td>hospital management</td>
</tr>
<tr>
<td></td>
<td>- Product model</td>
</tr>
<tr>
<td></td>
<td>- Instrumental model</td>
</tr>
<tr>
<td></td>
<td>- Boundary/less model*</td>
</tr>
<tr>
<td>Efficiency- (\textit{management})</td>
<td>regionalisation</td>
</tr>
<tr>
<td></td>
<td>- area management</td>
</tr>
<tr>
<td></td>
<td>- population-based resource allocation</td>
</tr>
<tr>
<td><strong>Micro level:</strong></td>
<td>evaluation of treatments (effectiveness)</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>- RCTs; Meta-analysis</td>
</tr>
<tr>
<td>(i)-collective</td>
<td>clinical autonomy (trade off between equity &amp; efficiency)</td>
</tr>
<tr>
<td></td>
<td>- clinical guidelines</td>
</tr>
<tr>
<td>(ii)-individual</td>
<td>clinical autonomy (trade off between clinicians &amp; management)</td>
</tr>
<tr>
<td></td>
<td>- physician-patient relationship</td>
</tr>
<tr>
<td></td>
<td>- accountability</td>
</tr>
<tr>
<td></td>
<td>- quality of care</td>
</tr>
</tbody>
</table>

*Refer to Braithwaite et al 1995b, p.87

Spending on health care per capita varies widely across countries (Pfaff 1990). As well as differences between countries, there are gross differences to be found between the health status of different groups within countries. The indigenous peoples of Australia, Canada, NZ and the USA have lower life expectancies, higher morbidity and lower living conditions than other groups within those societies. Many groups in the USA live below the poverty line and have higher morbidity and mortality than the mainstream society. (Pappas 1993) The implications for public policy of these findings of inequalities in health status are immense; probably so
immense and so complex that political intervention may not be possible until public opinion forces the issue.

"While detailed explanations of social variations may require research, the broad picture is beyond dispute. By lacking an economic component, the government's health policies have to address inequalities in health. At the same time, the government's economic policies have widened those inequalities. The explanation underlying both failures is a refusal to recognise the relation between economic policy and health." (Watt 1996, p.1027)

---

**Figure 4. Issues of Concern at the Macro Policy Level**

<table>
<thead>
<tr>
<th>Macro/political</th>
<th>1. Greater expenditure on health care systems does not give better health status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Finite resources and expanding needs = rationing</td>
</tr>
<tr>
<td></td>
<td>- research</td>
</tr>
<tr>
<td></td>
<td>- technology evaluation</td>
</tr>
<tr>
<td></td>
<td>3. Public versus private funding: ideal mix?</td>
</tr>
<tr>
<td></td>
<td>- insurance</td>
</tr>
<tr>
<td></td>
<td>- two-tier systems</td>
</tr>
<tr>
<td></td>
<td>4. Equity</td>
</tr>
<tr>
<td></td>
<td>- access to system</td>
</tr>
<tr>
<td></td>
<td>- outcomes (health status)</td>
</tr>
<tr>
<td></td>
<td>- curative/preventive services</td>
</tr>
<tr>
<td></td>
<td>5. Quality</td>
</tr>
<tr>
<td></td>
<td>- audits</td>
</tr>
<tr>
<td></td>
<td>- standards</td>
</tr>
<tr>
<td></td>
<td>- accreditation</td>
</tr>
<tr>
<td></td>
<td>- outcomes</td>
</tr>
<tr>
<td></td>
<td>- effectiveness of treatments</td>
</tr>
<tr>
<td></td>
<td>- side effects</td>
</tr>
<tr>
<td></td>
<td>- evidence based medicine</td>
</tr>
<tr>
<td></td>
<td>- guidelines/protocols</td>
</tr>
<tr>
<td></td>
<td>6. Accountability</td>
</tr>
<tr>
<td></td>
<td>7. Lack of information</td>
</tr>
</tbody>
</table>

Inequalities in health status within countries are related to the problems of equity, such as access to health care systems, but more specifically to factors outside the
health care system, such as unemployment and consequent social exclusion and deprivation. There needs to be co-ordination between the policy areas, as implied by Watt's quotation above. Inequalities between countries are related to the amount of resources applied to the health care area, the quality of those resources and how and where they are used, and the degree of inefficiency and waste at all levels. As the outline on data difficulties (above) made clear, the inequalities between countries may in fact be due to many causes other than the quantity and quality of health care system resources.

One of the major questions to be answered is: how much is enough for health care? The usual definition of the health care budget as a percentage of GNP never appears to be directly related to documented health care needs of a country. In recessionary times, the resources in real terms will be less, because total GNP will be less. It is precisely in recessionary times, with more unemployment, depression, alienation and deprivation that more health care services are required. It is this lack of matching of resources to needs which is common to each country. Richardson (1990) has questioned the adequacy of 8% of GNP in the Australian context, and Warshawsky (1994) has detailed actuarial and macroeconomic approaches to projecting health care expenditures as a share of GDP, but otherwise the literature is silent on this subject. The lack of needs analysis, which would identify medical and health needs in the social domain, has allowed the provision of health care to be perceived as an issue in the economic domain. Hence health care budgets are seen as budget-deficit problems requiring immediate solution, i.e. cost-cutting. (Thurow 1985) This is the approach in each country, but the USA's problem is exacerbated because of the number of for-profit institutions providing
health care. As Cassel (1996, p.605) remarks, profit is the problem in the USA's escalation of health care costs. (More than US$9 billion were generated as profits in a trillion-dollar health care industry in 1995.)

"This is money that is unavailable for medical needs at a time when policymakers solemnly agree that we 'can't afford' universal access to health care."

Figure 5 shows the issues of concern at the institutional level of health care policy. (This figure relates to Box 6 in the conceptual diagram (Diagram 1) to be found in the next section.)

**Figure 5. Issues of Concern at the Meso Policy Level**

<table>
<thead>
<tr>
<th>Meso/Institutional</th>
<th>1. Efficiencies - value for money</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Clinician/manager interaction - culture/environment</td>
</tr>
<tr>
<td></td>
<td>3. Equity - access to hospitals, clinics etc.</td>
</tr>
<tr>
<td></td>
<td>- outcomes</td>
</tr>
<tr>
<td></td>
<td>- variances</td>
</tr>
<tr>
<td></td>
<td>- DRGs</td>
</tr>
<tr>
<td></td>
<td>- rationing</td>
</tr>
<tr>
<td></td>
<td>4. Quality - customer satisfaction (includes patients &amp; clinicians)</td>
</tr>
<tr>
<td></td>
<td>5. Accountability</td>
</tr>
<tr>
<td></td>
<td>6. Lack of Information</td>
</tr>
</tbody>
</table>

It is at the meso level - at the coalface in hospitals and clinics - where patients and clinicians alike perceive the problem of too few resources. This problem results as strategies for macro-level cost-containment are put in place. As the population learns of the development of new technologies, 'wonder' drugs and life-enhancing treatment techniques via a media only too ready to publicise such issues with little evaluative analysis, the possibilities within medicine far outstrip the resources required to provide them. Politicians perceive problems when their constituents complain of waiting lists and other problems such as availability of certain programs, treatments and pharmaceuticals. and lack of access to facilities within
the area inhabited. But politicians realise that for more resources to go into health care means either raising more taxes or taking resources from other areas, both risky political strategies. Most politicians are happy to let the medical practitioners sort out the allocation of health care resources, by de-facto rationing processes such as the example of premature babies outlined above. Some politicians are happy to use the situation for political ends, and interfere in the resource allocation process, especially where ‘shroud-waving’ incidents are concerned.

Attempts at solving this (possibly unsolvable) problem occur at different levels, and not all solutions are available within all health care systems. The one strategy which always ought to be applied in conjunction with others is to try to ensure fairness and equity in the allocation of finite resources over an infinite number of requests. GPs in the UK and to a certain extent in Canada and Australia, are able to act as ‘gate-keepers’ to the more expensive part of the system which involves specialists and hospital care. At this level, the medical professional can help change the perception of ‘need’ which is held by the patient. An alternative course of treatment may be offered, or another agency recommended. Patients in the UK so far appear to accept this gate-keeping behaviour, but patients’ rights advocates are inciting changes. In the other countries, patients are at liberty to shop around until they find an accommodating medical practitioner. In the USA, it is even worse in terms of expenditure, as patients, instead of firstly attending a general practitioner, may self-refer to specialists, who charge more than GPs. Canadian patients may do the same, but the specialist may charge only the equivalent to the GP’s fee, so there is no incentive for specialists to encourage this behaviour. Australian patients may self-refer to specialists, but they are then
ineligible for the public Medicare refund. Other solutions include overt attempts at rationing resources, the provision of core services only and other variations on this theme. The Oregon experiment (see Chapter 5) is perhaps the most well-known attempt at proceeding rationally with rationing, but even this heroic attempt failed to produce an equitable (or indeed, rational) result.

At a practical level, in the event of smaller health care budgets, hospital administrators' short-term solution is to close operating theatres and/or wards, thereby limiting the numbers of patients and therefore the costs to the system. This of course only adds to the problem of waiting lists, or makes patients enter the private health care arena, a strategy which precludes members of the lower socio-economic strata and often those most in medical need. The longer term solution is to ensure that only cost-beneficial treatments are offered in the first place, but the information is not yet available to enable practitioners to use this strategy with any precision. While the provision of cost-beneficial treatments will save waste, it will not address the main problem of bridging the gap between what is technically feasible and the available resources for health care. Ultimately, equitable strategies for the rationing of resources will be required.

Reform at meso-level may involve new forms of organisation, such as health maintenance organisations (HMOs), preferred provider organisations (PPOs) and independent practice associations (IPAs) which operate as mini-national health systems, wherein for a contracted insurance premium, patients may obtain services within certain parameters, and doctors are contracted by the organisation to provide these services for set remuneration. (Bryce 1994) Other new forms of organisation occur in hospitals, where previously hierarchical management changed to a
functional matrix arrangement (Burns 1989), and in health department bureaucracies, where previously centralised departments are regionalised or decentralised. (Nicol 1984; Paton 1993) Other reforms at this level concern the commercialisation, corporatisation or even privatisation of certain functions, such as hotel services (cleaning, catering and maintenance) which are hived off from the management of the hospital. (Bovbjerg, Held & Pauly 1987; Jacobs & Nilakant 1996) The factors contributing to hospital sector problems include the degree to which the medical profession is involved in resource allocation (Labelle, Stoddart & Rice 1994), and the fact that the information required for effective decision-making has been lacking. There is little information on the relative costs of different procedures and medical treatments, their effectiveness or the costs of caring for individual patients. (Boyce 1996; Wray 1995) Too little attention has been paid to relative values in the pricing structures (Kronick, Goodman & Wennberg 1993; Palmer 1991; Voss 1994), with little monitoring of the effects of new technologies where they affect costs of treatment modalities. The management of hospitals as organisations has been inefficient, with limited flexibility of labour and resources. (McGuire 1987) The treatment of capital spending, being allocated separately from current spending, has not been commercially viable - when capital is ‘free’ to hospital management, the incentive to expand is too high, and there is no consideration of revenue affordability. In the UK in particular, the lack of incentive structure in the NHS management had led to under-usage and neglect of capital assets, including equipment, buildings and real estate. This occurred at a time when the NHS was being given increased budgets. Reform efforts to improve micro-efficiency in this sector have included
strengthening the role of payers so that they are both accountable to the state for
cost control, and as agents for health consumers with respect to assessing and
purchasing health care. (Pfeffer & Pollock 1993) Accountability for cost control
has been brought about by capped overall prospective budgets (at macro level) and
responsibility for choosing contracting arrangements with providers. (Hunter 1992;
Wall 1996) Under these reforms, funders must become better purchasing agents
for consumers, weighing up the relative merits and cost-effectiveness of different
treatment strategies and in selectively purchasing health services. (Marchment &
Hoffmeyer 1993; Milne 1993) Note that purchasers have different roles in
different health care systems. In the UK, purchasers are buying health care services
for populations; in the USA, they are buying on behalf of individual patients. (Jost
et al 1995) Funders, however, need price and cost information in order to carry out
these responsibilities. But this information is in many cases lacking or judged to be
commercially sensitive and unavailable to them. (Shwartz et al 1995/6) If taken to
its logical conclusion, this process would see purchasers trying to distinguish
between necessary and unnecessary care, thus encroaching on clinical autonomy.
Purchasers are being charged with the responsibility for evening-out the variations
in practice by comparing the results of doctors and hospitals. This is an area of
contention, and will evolve into future problems, already evidenced in arguments
for and against ‘better practice’ dictates of practice guidelines and quality
assurance methods. (Westert et al 1993; Wu 1995) The move towards more audit
and review of both type and volume of treatments may well reduce costs initially,
but the administrative costs for this over-sighting may negate such savings.
(Kerrison, Packwood & Buxton 1993; Lavis & Anderson 1996; Packwood 1996;
Phelps 1993; Pollitt 1993b) In order for purchasing-role reforms to work as intended, there needs to be actual competition between health care providers, either public or private. The theory is that, with the ability for purchasers to move funding from one provider to another, there will be strong incentives for providers to improve quality, efficiency, cost control and other elements in an effort to win supply contracts. This is the approach used in the UK, where GPs as fundholders have been able to contract with a range of hospitals and have been able to win concessions in terms of better service for their patients. (Glennerster, Matsaganis, Owens & Hancock 1993) This is also the basis for the funder-provider split in Western Australia (WA), but it is difficult to see how the same logic applies, as there is no GP fundholding (yet), and there has been no change in the methods of choice nor the range of hospitals from which to choose. Patients in WA have a far greater freedom of consumer choice than in the UK, and may change their GP as often as they wish, (or may see as many as they like concurrently) and are not constricted to the local hospital in their catchment area. Doctors in WA’s public hospitals have refused to contract on an individual basis with the hospitals, so this avenue of competition is also unavailable. Street (1994) outlines the options for Australia within a managed competition framework. It is doubtful that competition between health care providers is in the best interests of equity or quality of care. There is also the issue of the legality of contracting and the role of risk-sharing. There is a degree of illusion about purchaser/provider contracting, and a recurring theme in the literature is that the rhetoric of the markets cannot be taken literally. In the UK, the NHS contracts diverge dramatically from the classical model of contracts, as the parties are public entities not independent actors, and statutes and
regulation largely determine the terms of the contract; nor can contracts be enforced by law. Even in the USA, ideal free markets are only approximated, with contracts being negotiated between parties with considerable market power, and as in the UK, statutes and regulations constrain the contract terms. (Jost et al. 1995, p.890)

We should question the validity of contracts which deal with services which cannot be completely specified, and certainly not specified in advance. An obvious example is for emergency services, but any service is theoretically subject to enormous complexities. The use of the diagnosis related groupings (DRG) approach is useful, in that it gives purchasers some control over treatment intensity and costs, while encouraging suppliers to seek efficiency gains in the provision of treatment. However, outliers will be problematical, in view of the fact that costs falling outside the arrangement price of the DRG will need to be recouped from episodes which cost less than that specified. This may be an incentive to discharge patients too early, thus lowering quality of care. Mixed payment systems, comprising part DRG and part fee-for-service, or DRG with 'stop-loss' arrangement (where the balance of costs above a pre-set ceiling are paid by the funder), may reduce the risk exposure of providers. In systems such as the USA with a fragmented insurance market and a great deal of consumer choice, the role of funder as purchaser can only be implemented in PPOs and HMOs, which act as mini-integrated systems. Under such organisational structures, there are strong incentives to minimise unnecessary care, as well as incentives to under-provide care if there is not adequate competition between HMOs. Most research suggests that HMOs have lower spending than fee-for-service insurance arrangements; it has
been estimated by the Congressional Budget Office that if the entire population of the United States were insured under HMO arrangements (21% at present), then overall health spending might be reduced by 10% and health outcomes would not suffer. But there is evidence that health spending in HMOs grows at much the same pace as that under other institutional arrangements, suggesting that benefits from such a shift are likely to be a one-off concentrated in hospital services. (OECD 1994b, p.40,41)

Figure 6 outlines the issues of concern at the clinical level. (This figure relates to Box 7 in the conceptual diagram found in the next section.)

Figure 6. Issues of Concern at the Micro Policy Level

<table>
<thead>
<tr>
<th>Micro/Clinical</th>
<th>1. Physician-patient relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- patient equity</td>
</tr>
<tr>
<td></td>
<td>- paternalism</td>
</tr>
<tr>
<td></td>
<td>- clinical autonomy</td>
</tr>
<tr>
<td></td>
<td>- clinical guidelines; &quot;cookbook&quot; medicine</td>
</tr>
</tbody>
</table>

2. Clinical efficiency
- outcomes

3. Appropriateness of care

4. Quality
- caring
- trust
- communication

5. Accountability

6. Lack of information

Many treatments are actually ineffective, and whilst they might not harm the patient, the use of resources on such treatments is wasteful. The introduction of untried or insufficiently tested technology is wasteful and could ultimately be harmful. Regulation of the testing of new technologies, such as magnetic resonance imaging (MRI), and the regulation of the geographic placement of the
machinery, is required so that numbers of machines match the potential use without excess capacity. However, as Drummond (1994) points out, while economic evaluations of programs and treatments have been conducted for about 30 years, with an exponential rise in the number of studies being published, there is relatively little evidence of the use of these studies in decision-making about health technologies. Selby-Smith et al (1994) conclude that the roles and relationships of the various players in technology assessment need to be clear, that appropriate incentives are required if socially desirable priorities are to be achieved and that the application of economic appraisal techniques needs to be timely and relevant. (for health care technology in the UK see Spiby (1994); for Australia see Hailey (1994); for Canada see Battista, Jacob & Hodge (1994); and for a comparison of Australia, Canada, UK and USA see Battista et al (1994)) Attempts at solutions to the problem of not knowing which interventions work best include the provision of many more randomised clinical trials (RCTs), and meta-analysis (i.e. the combined results of RCTs) where trials are conducted in accordance with the requirements for such analysis. (Sacks et al 1987; Villar 1995) Other sources of data on patient outcomes include routine observational data from surveys, hospital discharge summaries, etc., and cross-design synthesis which combines RCT results and observational data. (Orchard 1994) Tannenbaum (1994), however, issues a note of caution, having found that American physicians rely on personal experience over research data, and view that data as useful but not definitive and in no way immune to the social influences on medical knowledge generally.

"The recent ascendancy of outcomes research is as much political as it is scientific, empowering the research community relative to practising physicians, lending medical legitimacy to payer-promulgated practice guidelines, and creating
additional clinical work around a false standard of medical certainty". (Tannenbaum 1994, p.27)

At the micro-level, reforms have attempted to change provider behaviour to make clinicians accountable for the expenditure of resources. Consumerism has pressed for attitudinal changes towards patients, for example pressuring governments into issuing Patients’ Charters (as in the UK and NZ) which concentrate on the ‘rights’ of patients. Such ‘rights’ include the promise that patients will spend only x time on a particular waiting list, that they will be given choice of treatments where applicable, and such-like. (see Ranade 1994 Chapter 7; Tailor & Mayberry 1995)

At all levels, reforms have altered the degree of clinical autonomy, changing the nature of the fiduciary relationship between doctor and patient, thereby indirectly providing a potential threat to the quality of clinical practice. Analysis of both the ingredients of policy and the products of the policy-making process is fraught with difficulties, and the complexity and confusion inherent in this policy area will ensure that the process is always messy, complicated and full of argument. Quite clearly, a framework for policy makers is required to at least ensure that all the issues are tagged as reminders to those charged with the difficult task of drafting policies which have at their core the objectives of the health care system, rather than reduction of costs. The following section offers a conceptual diagram as such a framework.
3. Conceptual Diagram of the Structure of Health Care Systems

### Box 8. Availability of Information
Reliability & Validity of Evaluation Techniques
Equity of decisions for society, providers, patients

### Boxes 5-7: Problems for Policy Makers & Decision Takers

<table>
<thead>
<tr>
<th>Box 5 Macro/Political</th>
<th>Box 6 Meso/Institutional</th>
<th>Box 7 Micro/Clinical</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>How much GNP</em></td>
<td><em>Regional/Central</em></td>
<td><em>Outcome Measures</em></td>
</tr>
<tr>
<td><em>Cost constraints</em></td>
<td><em>Rural/Metro</em></td>
<td><em>QALYs &amp; other cost/utility measures</em></td>
</tr>
<tr>
<td><em>Centralised/decentralised organisation</em></td>
<td><em>Managed Care</em></td>
<td><em>Individual needs versus community needs</em></td>
</tr>
<tr>
<td><em>Apportionment to Areas, populations, programs</em></td>
<td><em>Managed Competition</em></td>
<td></td>
</tr>
<tr>
<td><em>Indigenous People</em></td>
<td><em>Area needs</em></td>
<td></td>
</tr>
<tr>
<td><em>Evaluation</em></td>
<td><em>Cost constraints</em></td>
<td></td>
</tr>
<tr>
<td><em>Equity</em></td>
<td><em>Quality of Care</em></td>
<td></td>
</tr>
<tr>
<td><em>Accountability</em></td>
<td><em>Evaluation</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Quality of Care</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Equity</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Accountability</em></td>
<td></td>
</tr>
</tbody>
</table>

### Boxes 2-4: 3 Levels of Decision-Making

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding</td>
<td>Federal/State Distribution $$$$</td>
<td>Remuneration *Fee for Service</td>
</tr>
<tr>
<td><em>Revenue</em></td>
<td>Distribution Programs*</td>
<td><em>Salaried</em> <em>Capitation</em></td>
</tr>
<tr>
<td><em>Reimbursement</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Global Budgets</td>
<td>Levels of Care <em>primary</em></td>
<td>Practice <em>Solo</em> <em>Group</em></td>
</tr>
<tr>
<td>Health Insurance</td>
<td><em>community</em></td>
<td>Managed Care <em>HMO, PPO, IPA</em></td>
</tr>
<tr>
<td>Delivery</td>
<td><em>secondary</em></td>
<td>Evaluation Treatment Outcome</td>
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<tr>
<td>Workforce Supply *Education</td>
<td><em>tertiary</em></td>
<td><em>Individual Patients</em></td>
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<td><em>Training</em></td>
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<td>Public Health</td>
<td>Public Health <em>Hospital Organis'n</em></td>
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<td>Evaluation</td>
<td>Evaluation Health Status <em>Populations</em></td>
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<td>Technology</td>
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<td><em>Assessment</em></td>
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<td><em>Diffusion</em></td>
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### Box 1. Underpinnings of Health Care System

- **Political System**
  - Political Parties
  - Interest Groups
  - Philosophies

- **Economic System**
  - Market vs. planned
  - State Institutions
  - Ideologies

- **Public Opinion**
  - Individual vs. community
  - Sovereignty
  - Values

![Diagram 1. Structure of Health Care System and the Policy Process](image-url)
Diagram 1 is the structural model used as a framework in which to place the various elements of health care systems and the issues in health care policy-making. The diagram shows the ideas, aspirations and decisions which emanate from the political process (represented by Box 1: Underpinnings of Health Care System) feeding into the three levels of decision-making, designated as macro-, meso- and micro-levels. These levels are designated as Boxes 2, 3 and 4 and within them are listed the elements of funding, organising/delivering and evaluating health care systems at macro (legislative) level, meso (organisational) level and micro (provider) level. The contents of these boxes relate to the issues of analysis in Section 2 above.

Resources and information are passed from macro-level to meso-level and to micro-level and information is fed back. Impinging on the policy-making and decision processes within each level are problems, which are shown in Boxes 5, 6 and 7, which again relate to the different levels - macro (political), meso (institutional) and micro (clinical). The contents of these Boxes have been discussed in Figures 4, 5 and 6 above in the section on levels of analysis. Reforms to the system usually stem from the attempts to solve these problems. Impacting on the entire system are the problems and issues shown in Box 8. It is these problems which must be taken into account when attempting to solve the more particular problems. These issues concern the availability and quality of information, the reliability and validity of evaluation techniques, and the necessity to consider equity for all stakeholders - society, providers and patients - in the decision-making process.
4. Conclusion

This introductory chapter has set out the aims and objectives of the research, and has described the environment in which health care policy is made as both complex and confusing, with uncertainty as its enduring attribute. Issues which require discussion have been briefly mentioned, and the method of analysis which will utilise the macro-, meso- and micro- levels of policy has been outlined. The problems inherent in both the making of policy and in its analysis have been introduced as stemming on the one hand from cognitive difficulties, including an inability to think laterally and to include non-economic factors, and on the other, from the inconsistencies of data collection and lack of adequate information. A conceptual diagram has been offered as a framework in which to place issues at their various levels, and to show the direction of communication flows. This chapter then has set the scene for the rest of the work. Each of the following chapters has the same weight as far as importance to the overall discussion is concerned, and several of them could logically follow next. It is therefore a matter of looking first to the general, then proceeding to the more specific. Chapter 2 discusses the definitions used in health care systems and policy, with Chapter 3 outlining the objectives of health policy as preferred by OECD countries and the different methods used in the organisation of their health care systems. Chapters 4, 5 and 6 review the substantive issues which ought to underlie health care policy, while Chapter 7 reviews the reforms which have been instituted. Chapter 8 concludes with the hope that future policy will better reflect the need for health status, quality of care and clinical autonomy amongst other factors to be given as much consideration and prominence as budget deficits and bottom-line accounting by policy makers at all levels.
Chapter 2. DEFINITIONAL PROBLEMS in HEALTH CARE POLICY

"Theoretical incoherence pervades health care policy across the globe, and it is difficult to see how such systemic intellectual incompetence can be cured. However, if health reform is to be truly managed, those in government with responsibility for such matters must be in a position to think through their policies, and so must adhere to proper intellectual standards." Editorial, Health Care Analysis, 1994; 2(1):1-4

As noted in Chapter 1, definitional problems are to be found throughout micro-, meso- and macro- policy levels, and will impinge on all facets of policy-making. In terms of the structural model (Diagram 1, p.43), definitional problems may be included in Box 8 as a facet of availability of information. If 'proper intellectual standards' are to be agreed, then consensus on the meanings of conceptual definitions is required. For example, 'health' policy and 'health care' policy are sometimes used interchangeably, but they are not synonymous. Health policy focuses on disease states and deals with communicable disease control, vaccination of populations and such programs. Health care policy focuses on disparate areas such as the financing of health care systems, provision of treatment to individuals by medical and allied health personnel, the organisation of hospital systems and the dissemination of new technologies. With the reduction of budgets, this includes the making of priorities to decide which areas of health care provision to fund and which must go without, and at patient level, which individuals will be treated and who will not, and the levels of expenditure permitted which will preclude certain treatments. This chapter looks at some of the problematic concepts and definitions to be found in health care policy-making and analysis.
1. Health and Health Status

'Health' as a status of being is not brought about solely by the provision of 'health care'. There are many factors to consider as inputs to the health status of people: genetic inheritance, environment, luck and personal circumstances on an individual level (i.e., the socio-economic status of individuals and families), and other areas of policy dealing with sanitation, quality of housing, the availability of clean water and other 'social or public goods' areas. Many studies have shown the correlations between lower socio-economic status and ill-health. (Adler et al 1993; Barker & Osmond 1987; Black 1993; Carr-Hill 1987; Davey Smith & Egger 1993; Davey Smith, Bartley & Blane 1990; Davis 1991; Hurowitz 1993; Phillimore, Beattie & Townsend 1994; Townsend 1991; Townsend & Davidson 1982; Watt, Franks & Sheldon 1993; Whitehead 1992; Wilkinson 1994) It is not understood how specific socioeconomic factors determine variations in mortality from chronic diseases, and so reduction of inequalities in mortality can only be conjectured. A study by Blaxter and quoted by Townsend (1991) concluded that for poorer groups, material deprivation which is a lack of decent standard of housing, sanitation, work safety etc., is the key causal factor in explaining premature death and poor health in Britain. There is mounting evidence that psychological depression as experienced by newly unemployed people is also a causal factor. Research by Ettner (1996) produces new evidence on the relationship between income and health. UK data was taken from the National Survey of Families and Households, the Survey of Income and Program Participation, and the National Health Interview Survey to estimate the structural impact of income on several measures of health status. Results suggest that cost-benefit analyses of government
policies that may reduce disposable income should take into account the potential effects on morbidity. The Editor of The Lancet, commenting on the fact that the rich are healthier and live longer than the poor, suggests that

"no amount of statistical juggling by government departments has managed to obscure the over-riding correlation between poverty and ill-health. Those charged with improving the health of nations have not, of course, opted for redistribution of wealth as a solution. World wide, preservation of health is slipping inexorably down the priority list of governments' expenditure". (The Lancet, 4 May 1996; 347(9010):1197)

Charlton (1994), suggests however, that inequalities in health are less a sign of deliberate failure to address deprivation than an unintended consequence of success in expanding advantage. The deprivation model of sickness is a negative model: negative health is caused by negative social conditions, e.g. cold, dampness, filth, infectious diseases. The idea that redistribution of wealth and income as the single most effective strategy for abolishing poverty and improving the community's health "has reached the status of orthodoxy in some medical and sociological circles". Charlton argues that research into health inequalities has moved the debate to a new agenda, inadvertently undermining the deprivation model in the process. Findings suggest that health inequalities are universal, finely stratified, and extend from top to bottom of the socioeconomic scale. Inequality is not caused by deprivation or poverty in an absolute sense, but is a consequence of the distribution of social advantages. Thus "health inequality is not necessarily an index of poverty or injustice; it is found even in the wealthiest and most egalitarian societies." The more precise measurements of instruments for classifying socioeconomic position have increased the degree of detection of inequality. Health stratification occurs in all socioeconomic levels, so the relation between socioeconomic position and health
status is incremental. Charlton quotes the work of Davey-Smith and colleagues as providing a plausible explanation: socioeconomic factors are markers representing differences in life trajectory between social classes. People with higher occupational status and incomes would tend to enjoy ‘multiple long-term advantages’ - better environments, living conditions etc., and it is this cumulative life trajectory that is the explanatory variable for health outcome. Those with multiple long-term advantages are more able to accumulate more positive health. Charlton introduces his concept of a ‘salutogenic model of health’ as the best explanation of socioeconomic differentials. Salutogenesis is the process of health creation and regards health as the abnormal state.

"Life is maintained in the face of endemic environmental hostility to the organism. Health - far from being a natural state or a universal right - is an achievement, a privilege, and a consequence of good luck". (Charlton 1994, p.221)

Good health is made possible by social arrangements, and positive health is the achievement of a positive environment. As Charlton says, the consequences for policy are profound. If ‘good’ health is caused by advantage, then redistribution of advantage would not necessarily result in a net gain of ‘good’ health for the population; it may simply transfer ‘good’ health from the rich to the poor. To create more ‘health’, i.e. to give a net gain, policy should aim to increase the proportion of the population at higher socioeconomic levels. But Charlton argues that redistribution of income and other resources has little to offer in improving the national health: it is merely robbing Peter to pay Paul. Egalitarian policies do not so much create (good) health status, as move it around. He offers no clues as to how to reduce the proportion of the population at the lower socioeconomic levels,
without the use of redistributive policy. Presumably, he relies on growth in the economy to engender more job opportunities for those people in the lower socioeconomic levels, in the so-called trickle-down effect. Whatever the reasons, in Britain during the 1980s there was an unprecedented widening of income differences and growth of relative poverty. Wilkinson (1994), in a BMJ Editorial, quotes the official figures of incomes after taxes and benefits, adjusted for household size, which show that at the start of the decade, the incomes of the richest 20% of the population were four times as large as those of the poorest 20%.

By 1991, they were almost six times as large.

"That the late 1980s saw not only the most rapid part of this unprecedented widening of income differences, but a simultaneous cessation in the long term fall in national mortality rates among men and women aged 15–44, begs questions about the relationship between the two. .... Policies intended to divorce health from deprivation have proved largely ineffective. Reducing the burden of excess mortality attributable to relative deprivation depends on reducing social and economic inequalities themselves".

This period in the UK coincides with the Thatcher Government's strategy to recast the role of government, resulting in upheavals all through British society. The same process and outcome are evidenced in New Zealand, where there are now greater differences between top and bottom rungs in the socio-economic scale. Whether New Zealand will suffer in terms of health status remains to be seen. Given the correlation between unemployment and ill health, it is likely to be the case. If we were to use Charlton's model to consider the case of the health status of the majority of Australian Aboriginals and their higher rates of mortality and morbidity, it is clear that, notwithstanding the large investment in health care provision to these communities, there can be no health gain until living conditions are improved over time. Policy should be aiming towards improving the environment so that
incremental accumulation of social advantages takes place. The provision of running water, sanitary living conditions and education in the steps for basic hygiene would be worthwhile strategies, and more cost-effective than the proposals to inject extra monetary resources into the 'Aboriginal Health' policy area. The intransigence of Aboriginal populations to embrace the European mode of living must also be addressed for any benefits to accrue, once again showing the need for policy makers to acknowledge health care as but one part of the total social scene.

'Health' has been conceptualised both positively and negatively. One focus of 'health' is on the absence of disease, so that as long as all the bodily organs are functioning within 'normal' parameters, the person is 'healthy'. 'Normal' usually refers to parameters defined relative to the average for the population.

The identification of consistent health differentials between subgroups of populations has placed greater emphasis on the relationship between individual circumstances and social structures. The importance of social factors in the development of many diseases has become increasingly clear, despite persisting uncertainties about the actual causative mechanisms. (Australian Institute of Health & Welfare 1992, p.18) This in turn focuses attention on the inequity of those health status differences over which individuals and sectors of society have, at most, limited control. Whether or not these issues are accepted as being relevant by decision-makers has ramifications for policy: should access to the health care system be based on health care as a social good, as a citizen's right, or as an 'earned' right and therefore a 'deserved' right? [See below, Chapter 5, Health Policy in the Context of Social Justice ]
Another focus is on the multiple dimensions of health. The World Health Organisation (WHO) defined health as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’, a definition described by Bates & Lapsley (1985, p.227) as

"most unrealistic, which has bedeviled societies ever since. ..... This definition is patently absurd and unattainable, but because it sounds inspiring it has been constantly quoted as an ideal towards which we must work. However, there is little point in setting up goals that can never be properly defined, let alone reached. How can we tell whether anyone at all, let alone a whole nation, has achieved the complete state of well-being? How can we measure it, evaluate it, or even understand what we need to do to move towards it?"

The need to agree on the meaning of ‘health’ can thus be seen to be extremely important for policy making and analysis. The meanings of the related terms ‘inequalities’, ‘inequities’ and associated concepts are detailed later in this chapter. Bates & Lapsley argue that large-scale policy issues are arising, especially from the advances in technology, and for the need to have, as an underpinning, a concept of national priorities and needs, and

"an acceptance that although every human life is equally valuable to its owner, the same amount of effort cannot be devoted to preserving each life."

The recognition by researchers in the last two decades of the contribution of multi-sectorial factors to health status has given rise to the concept of ‘healthy public policy’. Much of the ill-health of a population may be attributed indirectly to factors arising from public policies which did not recognise implications for health status. Such public policies include economic strategies to lower inflation at the expense of employment prospects. There is evidence to show that higher unemployment is a direct cause of greater ill-health in the community, and the association between social position and health status is well documented. [For a
review of this evidence see Jin et. al., 1995] Summarizing the evidence of a decade of research, Whitehead (1987) concluded:

"Whether social position is measured by occupational class, or by assets such as house and car ownership, or by employment status, a similar picture emerges. Those at the bottom of the social scale have much higher death rates than those at the top. This applies at every stage of life from birth, through to adulthood and well into old age." (Whitehead 1987, quoted in Ranade (1994, p.128))

Health policy makers need to show cognizance of this, and the fact that the actual contribution of health services to the public's health is not clear, largely because of the lack of data on appropriate measures of health outcomes.

1.1 Measuring Health Status
The epidemiological instruments by which health status is measured cannot provide the information necessary to assess the contribution of health services to the public's health. Development of instruments to measure quality of life, such as quality-adjusted life years (QALYs), healthy-year equivalents (HYEs) and disability-free years may help to overcome some of the knowledge gaps, but there exist conceptual problems with such instruments. (Culyer & Wagstaff 1993, 1995; Carr-Hill 1991, 1992, 1994; Williams 1987, 1991). Data on life-years gained after intervention, the quality of those years and the costs in obtaining them, is required before accurate assessment of the impact of health care services on the population's health can be made. Presently, epidemiological instruments such as mortality and morbidity statistics, life expectancies (at birth and other ages) and neonate and infant mortality give only macro-level information which is viewed as both outcomes of the health care system and as an input to the planning process for funding and provision of future health (i.e. preventive, curative and rehabilitative)
care. As mentioned above, correlations between these data and socio-economic data of populations show strong evidence of worse health status the lower the socio-economic status. This has ramifications for health care reforms, which must take into account the consequences of changes in policies at various levels in the health care system. Global cost cutting at macro level, for instance, would deprive the less healthy, and by implication, the poorer, of care. Policies which provide disincentives to providers to practice in rural areas, or offer particular services rather than others, may further disenfranchise already disadvantaged groups within a society.

1.2 Government Goals and Their Evaluation

Each health care system needs to have a clear conceptual and operational definition of health on which to base its goals. The basis on which such a definition rests should be formulated from the expressed wishes of the population, via the political process. Brook & McGlynn (1991) suggest that the principal goal of a health care system should be to maximise the health of the population, and the evaluation of the success or otherwise of the realisation of that goal is measured by the quality of care. This is a utilitarian point of view which confuses the issues of 'health' of the community-as-a-sum-of-individual-patients (i.e. an epidemiological view) and the health status of individual patients. 'Quality of care' has to be context-specific, that is on an individual patient basis, to mean anything in terms of success evaluation. Otherwise, the result has to be judged on morbidity and mortality data. As the USA, which boasts the best care in the world, has the worst morbidity and mortality figures of the OECD nations, it is illogical to evaluate the success or otherwise of the maximisation of the health of the population by the 'quality of care' indicator.
Another form of evaluation for health care goals is the measurement of outcomes, but, as Hunt (1994) points out, while the concept of 'outcome assessment' in the provision of health services has grown, the measurement thereof is characterised by unsystematic, ill-defined and uncoordinated studies. There has also been the tendency to conclude that all 'outcomes' are of the same kind, and can be measured in the same ways. Since all outcomes must be related to the nature of the intervention (which might be medical, surgical, drug treatment, nursing care, public health initiative, etc.,) and could include such variables as alleviation of suffering, improved health status and/or quality of life, return to work, etc., then the measurement of such aspects of 'outcome' is problematic. Subjective variables such as these cannot be measured in the same way as clinical variables such as average blood pressure or electrolyte ratios. Added to this is the focus of the evaluator: patient, doctor, administrator, economist, policy-maker or some other stakeholder. If an outcome is judged to be clinically successful, but the patient is not satisfied, whose view will dominate? Timing is also a factor for consideration: when is an 'outcome' a single event and when is it part of a continuing process? As Hunt points out,

"it is unfortunate that outcome assessment appeals to all sides of the political spectrum, from those who wish to see more consumer input and to listen to the voices of patients, to those who want to create the illusion of providing 'value for money' in the medical marketplace. Where some activity is acceptable to all parties it is more likely to pass unexamined." (Hunt 1994, p.51)

If we cannot agree on the more tangible aspects of health care systems, what hope is there for agreement on the ethics of resource allocation? Who will define the values, the concepts of goodness, morality and health itself, that lead us to make such decisions and to choose one path over another? (Leeder 1992, p.6)
While Brook & Glynn's goal of maximising the health of the population may serve at a macro-level, it does not help in devising strategies for health care systems. It is as much a 'motherhood' statement as are the goals of 'efficiency, effectiveness and economy'. The following goals might be more conducive to having specific objectives defined and strategies implemented, so that the goals may in fact be attained and their results evaluated.

**Goal 1.** A health care system in a western democracy should offer universal and equitable access to reasonable health care provision.

This goal presents the problems of defining 'equitable', as some people will require much more health care than others, and 'reasonable', which is subjective and which would need to define each type of treatment, and the quantity and quality of each treatment. Both NZ and the USA have tried to define such 'core treatment' lists but have found such a task too difficult.

**Goal 2.** Such a system must be able to control health care costs to a reasonable level.

Once again, a definition of 'reasonable' will mean different amounts to different people, and it begs the question as to why most OECD countries have struck the rate at around 8% of GNP. To link health care finance budgets to a percentage of GNP is particularly illogical, given that in recessionary times, total GNP will be less, allowing fewer resources available at the time of greater medical need, given the higher unemployment and sickness rates in such times. The 'control' of such a system assumes that legislation is available to regulate the health care market, and indeed that a 'system' is in existence. In the USA, there are many 'systems', but no
overall health care system as in the other four countries. Nor can there be control
over overall costs where profit is part of the equation.

Goal 3. The health care system must make effective use of resources.
Given the uncertainty surrounding the efficacy of most medical interventions, the
variations in practice in all areas of medicine and the lack of costing data in the
hospital systems, this goal presents probably the largest problem of all.

To attain these goals, much more information than is currently available is
required. In the meantime, specific health care goals and targets - such as lowering
smoking rates, lowering heart disease rates, attaining a nominated percentage of all
children vaccinated for nominated diseases - are now being promulgated by many
countries, mainly in response to the WHO's 'Health for All' initiative. (WHO 1995.
For Canada's goals see Fraser-Lee & Howell 1993; for NZ's goals see Beaglehole &
Davis 1992; for Australia's goals see Australia. Commonwealth Department of
Health, Housing and Community Services 1993, Nutbeam 1993; for USA's goals
see United States of America. Department of Health & Social Security 1992; for
UK's goals see United Kingdom. Department of Health 1992) The Health for All
program is concerned not only with the improvement of health status, but with
organising principles considered vital to the process of attaining better health across
all population groups

2 Health and Health Services
However 'health' is defined, its principal determinant is NOT the quantity or quality
of 'health services'. The confusion of these two terms is born of a long-standing
and counterproductive misconception about health care provision. Health services
*per se* will not ensure a healthier populace, but may cause some minimal decrease in morbidity for a specific disease, or a slight increase in life expectancy. McGregor (1995, p.571) points out another problem with confusing health and health services:

"When we label things such as smoking, alcoholism, drug abuse, delinquency, child abuse, suicide and violence as 'health' matters, we create the illusion that they are problems to be dealt with by health care professionals and health care authorities. Caring for the victims is rightly a concern for health care providers, but correction of the causes is far beyond their responsibility or power."

A recent example is the 'hijacking' of the gun-control issue in Australia by the public health departments, which view the apparently growing incidence of gun massacres (e.g. in particular in Victoria, Tasmania, New Zealand and Scotland) as a 'health' problem. The only health factors associated with such tragedies is the probable mental instability of the perpetrators, which is an important issue but has nothing to do with gun control, and the injuries sustained by the injured victims, who must be attended by health care professionals. The only justifiable involvement by public health departments would be to encourage their respective ministers of health to put more resources into the mental health arena, in the hope that mentally deranged people might be recognised and denied gun ownership rights and so prevent such shooting tragedies.

Health services, and therefore those who provide them, cannot be blamed for the (ill) health of the population, nor can health services necessarily make the population healthier by being better resourced. Better health requires other priorities, such as employment opportunities for those of working age, and proper nourishment and care for children and the elderly. If health services costs are growing, it is because more services and/or more expensive services are being provided. The only way to stop cost escalation is to be more selective about the
services provided. This may well mean rationing services. If priorities are not carefully thought through, the results will be inequitable or unjust to some people. The major problem is lack of knowledge about the efficacy of treatments. It is likewise the problem in the organisation of health services, as data is not available on the efficiencies of services, nor the efficiency-quality trade-off. The measures now being utilised to try to stop cost escalation, such as total quality assurance, clinical treatment guidelines and technology evaluation, may help to attain quality standards, but will only help stop the cost spiral if used in conjunction with the provision of fewer, not more, services each year.

2.1 Curative or Supportive Health Care Services?

Health care has two distinct strands: one concerns the 'curing' of medical illness and surgical complaints, alleviation of trauma and the like, and is essentially an intervention-oriented, technical form of care based on clinical science and its accoutrements. The other form is non-technical, and supplies to the patient those qualitative aspects of care which are very often the factors identified by the patient when judging the 'health care episode'. Such factors include the attitude of health care professionals, the time taken in talking to the patient, empathising with the patient's predicament, and generally showing that the patient is valued as a person by the provision of supportive care. In most health care systems, it is the technical caring (curing) which is viewed as the important form of caring, and the non-technical form is undervalued, except for the extent to which this form is seen as contributing to the outcome. Gorovitz (1994) asks if caring is a viable component of health care - is it important or superfluous, prohibitively costly or affordable, obsolete or essential?
"The attitudes and behaviours that constitute caring affect both the quality of the patient's experience and the outcomes of medical care. They can be identified and can be nurtured or discouraged by the structures of organisation and financing within which health care is provided. They have costs, so their viability is threatened as pressures increase to make health care more economically efficient. Yet the value of caring behaviour may justify what is necessary to sustain it. This issue deserves prompt and extensive debate as health care systems undergo revision throughout the world." (Gorovitz 1994, p.129)

Gorovitz argues that any assessment of quality in a health care system must be based on a prior determination of what the significant dimensions of quality are for that system. Most evaluation lacks careful analysis, resulting in vague goals such as 'effective, affordable, patient-centred care', and given the context of high-technology and fragmented super-specialties in which the practice of medicine is now carried out, it will be difficult to foster the recognition of the value of non-technical caring. The traditional doctor-patient relationship of earlier, less technical times, which sustained the non-technical caring, has been supplanted. The traditional concepts of 'service' and 'healing' also have been supplanted by the concepts of economics: input/output ratios, resources/outcomes analysis, cost-utility analysis and suchlike. In this culture, 'caring' may be seen as being beyond the reach of organisations in the search for greater cost efficiencies and general 'reform'. Note that this applies to western democracies rather than lesser-developed countries, where the non-technical caring form is more dominant. If more high-technology care were available in non-Western systems, it would be interesting to see whether these developing countries followed the Western democratic example in allowing the economic perspective to gain the upper hand, or whether the culture would allow (or demand) the non-technical caring to continue. Whichever aspect of medical attention - curing or caring - is under
discussion, it must be remembered that ethics should underpin health care decisions, because there is no problem which can be solved solely by the application of economic theory. Speaking on the topic of budget cuts in the health care system, Chalmers comments that modern economic rationalists would argue that such decisions could be made on economic principles alone, and most seem to have forgotten that

"some of the great classical writings by people such as Adam Smith were soundly based on ethical considerations... There are many instances in modern medical practice where there is no right answer - just hard choices that have to be reasoned through." (Chalmers 1994, p.47)

3 Health Care Need

The concept of ‘health care need’ is, like the concept of ‘health’, value-laden. To have a need for health care is to fall short of what, in the context of the particular society and its health care system, is considered to be a reasonable level of health, or health status. What counts as a need depends on what level of health is seen as attainable and reasonable to expect, and therefore will have to depend on some assessment of what is practicable in health care. Some of the factors which are to be taken into account in this assessment include the cost of meeting the need; how much of the need can or cannot be met; availability of alternative methods of meeting the need; and the urgency of the need. Conflict also exists in the debate about the links between the existence of recognised needs and the right to their satisfaction. (Gough & Thomas, 1994)

There are many problems in analysing the concept of health care need. At the macro-level, the framework of the socio-economic system and its place in the capitalist-socialist continuum will provide rationales for the adoption of the meaning
given to the concept. It will depend on the amount of government regulation in the health care ‘market’, and the attitude towards the inclusion of private finance in the funding will largely determine a society’s attitude to ‘need’. At the micro level the methods for assessing a person’s state of health are imprecise, and it must be questioned as to whether or not the differences between the base standard and an individual’s status can be quantified. How can different patients’ needs be ranked, when those needs are not similar? For example, how can the need for pain relief in one person and the need for more mobility in another be ranked? The problems of assessing health care need must be understood when grappling with such concepts as Quality Adjusted Life Years (QALYs), which in turn underpin attempts made for rationing the provision of health services. The concept of health care need is also important to policy-makers when, in their efforts to economise, they analyse such issues as the provision of ‘core’, or ‘basic’ health care. Efforts in Australia, Canada and particularly New Zealand and the state of Oregon in the USA have demonstrated how extremely difficult it is to provide such a set of interventions while simultaneously providing equity and keeping within financial guidelines. [See Chapter 5 ]

Another problem associated with health care need is: how much health care is needed? For example, care of the critically ill in intensive care units (ICUs), or heroic care for the critically ill neonate or the critically ill aged. It is accepted wisdom that 20% of all health care resources are expended on patients in the last four months of life. In the USA, 40% of Medicaid expenditure is on people in the last four months of life. (Smith 1996) The clinical culture of the medical model suits the ‘doers’ - this type of person has the philosophy that doing something must
be better than doing nothing - and the resultant activity saves lives which would almost certainly be lost without it. But is this morally right, given that this action affects the patient radically? Will a patient who is left in a worse state, but still alive, be grateful to the interventionists? The problem is, clinical data are very often not available to help with decision-making in terms of 'how much' health care is needed. As Sundstrom (1994) points out, research is steadily going on in order to improve this situation. But clinical science is most of the time statistical science, while what counts in clinical medicine is not statistical averages but real individuals of flesh and blood. (See also Diamond & Denton 1993)

The issue of 'how much' health care raises the topic of 'living wills', which show that a patient has considered outcomes and options, and in certain circumstances, refuses any further treatment. Some ethicists see this as the start of a 'slippery slope' to further patient-actioned circumstances, such as having medical professionals help the patient to their death. In Australia, the debate on euthanasia has been rekindled by the passage of legislation in the Northern Territory allowing medically-assisted termination of one's own life, and the subsequent overturning of that law by the Federal Government. The debate has shown the depth of feeling on both sides - those who espouse the view that it should be everyone's right to decide their own time of death in the face of a painful lingering illness, or loss of dignity; and those who argue that all human life is sacrosanct, and such an action as assisting someone to take their own life is simply murder. Some palliative-care medical personnel appear to think that if care of the right type - e.g. freeing the patient from pain - is provided, nobody should think about having to take their own life. Harrowing stories of patients' dependence on others and their loss of dignity
and self-esteem, are overlooked by those who would consider only the technical solution. Living wills, euthanasia and the degree to which patients have autonomy over what happens to them in medical facilities are issues providing both lay and medical personnel with an ethical dilemma of great proportion.

3.1 Perspectives of ‘Need’

Health care need can be viewed from the perspectives of the patient, the health care provider, and the payers for that care. The administrators and policy-makers in health care systems all profess to wanting to put in place strategies which will elicit from the community in general and from patients in particular what it is that is needed. It is most important to clarify the difference between ‘need’ and ‘want’. The health care provider uses clinical judgment to determine what is required to return the patient to the chosen health status - that is, ‘medical’ or ‘clinical’ need. The patient, on the other hand, may have different ideas, and in certain health care systems may be able to ‘shop around’ (at no financial cost to the individual) until a provider is found whose clinical judgment is in agreement with the patient’s wishes.

But, as Gough & Thomas (1994, p.34) point out,

"the idea that individuals are the sole authority in judging the correctness of their wants is severely compromised, once we admit limits to people’s knowledge and rationality".

Indeed, how can a patient rationally judge medical (surgical, pharmaceutical, therapeutic) need if he/she is ignorant of body systems, medical and other therapeutic procedures, and all the other knowledge required in order to make a diagnosis and prescribe treatment? In the UK, general practitioners act as the ‘gatekeepers’ to the NHS system, ensuring that ‘needs’ not ‘wants’ are satisfied. In the USA, Australia, Canada and to some extent New Zealand, the patient is able
to 'shop around'. If it is the patient who is paying for the health care, should government policy be able to prohibit the gratification of that patient's perceived need (or want)? Should policy-makers decide on 'core' health care services? Even if this were desirable, it is proving to be an elusive goal. (Ham 1995) Should administrators be able to dictate treatment policies in an effort to contain costs? Who should decide on the standards of quality of care, when resources are limited? These are questions which ought to be at the heart of health care system reform, with input from all stakeholders including the general public.

In the USA, the cost of treatment may be covered by insurance, but in many circumstances the patient could be required to pay out of his/her own pocket. In Australia, Canada and New Zealand, the cost may be subsidised by government or private insurance. There are cost implications for policy-makers in the adoption of the precise meaning of the concept of need. The rise of the consumer movement, patients' rights groups and related pressure groups have focussed on this issue, by claiming 'rights' within the decision-making process in the clinical arena. There are signs that these inroads into the doctor-patient relationship may well be counter-productive in terms of both quality of care and cost efficiency. [See Chapter 6. Clinical Issues]

3.2 Maximisation of Benefits: Individual versus Community

In terms of health care policy, the major problem related to need is the utilitarian concept of trying to maximise benefit - in this case the benefit of (good) health - to the entire population. If policy attempts to provide the best for the most, what happens to those individuals whose legitimate (i.e. medical/clinical) needs are not met? Can individual sacrifices be justified in order to satisfy the needs of larger
groups? And who provides the justification? Daniels (1994) classifies this as 'the aggregation problem' - when should we allow an aggregation of modest benefits to larger numbers of people to outweigh more significant benefits to fewer people? This moral problem is exacerbated by the attempts of health economists to rank treatments by cost-utility analyses. The Oregon experiment attempted to solve the problem, by listing treatment-condition pairs ranked by cost-benefit calculation. The process, however, threw up rankings which appeared completely counter-intuitive, such as tooth capping ranking higher than appendectomies. The simple aggregation of many capped teeth yielded a net benefit greater than that produced by one appendectomy. This problem is allied to that of trying to establish core or basic health care treatments.

3.3 Models of Need - Aging

Policy makers will have various views about need, which will help shape subsequent service provision. Wilson (1991) shows how different models of aging can affect allocation of resources. The common western view on aging holds that old age is a time of inevitable and increasing dependence, and this assumption informs health policy, with subsequent service provision which emphasizes dependency rather than rehabilitation. An alternative model which more closely reflects the majority experience of aging today, suggests that older people may need help and/or treatment for a number of episodes over a period of time, but generally can take care of themselves. This model would not require the same amount of resources as the first model, but does not appear to be part of the assumptive worlds of policy makers or service providers, or even of old people themselves. Wilson argues that the perception of the environment of policy makers is out of date where old age and
the needs of the aged are concerned, and the paramount assumption of decline appears to make it difficult to conceptualize other aspects of aging. The number of people who now live beyond 65 years has increased, and the number aged 75+ is set to rise still further. Two points of view about aging and disability, asserted with equal confidence, maintain that

1) increasing numbers of old people mean increasing rates of disability, and
2) that older people are becoming more healthy.

While both views may be true, it would be helpful to know for which sections of society, and to what degree, they are valid. Policies will differ according to whichever of these views prevails. Wilson further notes that models all seem to be based on males, although the majority of old people is female, and policies based on men's experiences are not necessarily going to suit women. An unproven assumption which “pervades apparently scientific demographic and epidemiological studies” is that disability is a once and for all condition, like death. Wilson argues that the impact of chronic disease can vary over time, and disability, in terms of being able to live an independent life, is “very much a matter of environment and can increase or decrease over time”. The problem with the assumption of the continuity of care model is that rehabilitation attempts are discouraged, and the need for frequent reassessment is downgraded. The assumption of dependency reinforces the model of service provision which encourages dependency. Wilson points to changes in the British view, declared in the government's 1989 White Paper Caring for People, which shows that the new emphasis on effective use of resources and correct targeting is accompanied by “an implicit recognition that not all older people belong on the conveyor belt”.

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“Many people need some extra help and support at some stage in their lives, as a result of temporary illness or disability. Some people, as a result of the effects of old age, of mental illness, including dementia...have a continuing need for care on a long term basis.”

(UK DoH. Cmdn 849: 10, quoted in Wilson 1991 p.44)

The various models of health care provision and their underlying assumptions and values must be made public by policy makers so their resultant decisions and policies may be legitimised by those people who will be the recipients of care.

4 Health Care Demand

4.1 Supply-side/Demand-side

When people perceive that they have a medical or other health-related problem, they translate the problem into a ‘need’ - to go to the doctor for advice, perhaps a surgical operation, or for a drug prescription. When such a felt need is acted upon, the patient makes a demand on the health care system. In economic theory, demand is the quantity of a good or service which consumers are able and willing to buy at a given price in a given market during a specified time period, other things being equal. The price of the good has an effect on demand: in normal demand, an increase in price causes a decrease in demand. Demand theory tries to explain and predict consumer behaviour, but for health care demand it has the problem of the good being free to the patient at the point of delivery (in most cases, and excepting the USA), so there is no price to affect demand. The health care ‘market’ also suffers because there is not perfect information available (another criterion for market theory), with the doctor acting as an agent for the patient, not as an equal in an exchange mechanism. (Mooney & Ryan 1993; Pontes 1995; Propper 1995)

Instead of looking at individuals' demand, economists make the medical practitioner
the driver of health care demand, because it is the doctor who decides which
resources, and the quantity, which are to be utilised in satisfying the patients' needs.
There are macro-economic ways to keep demand within limits in the institutional
setting, but at the micro-level of the patient-doctor interface in ambulatory care,
keeping a cap on resources used is not so easy. It is difficult to see how the reforms
to the health care systems can assist at this level, especially if clinical autonomy is to
remain intact, yet it is precisely in the personal health care arena where work needs
to be done to find the balance in the equity/cost-efficiency continuum. The UK
government has taken the unusual, but welcome, step of telling people not to bother
their GPs with a visit to the surgery when they have a simple cough or a cold. Self-
treatment via the local pharmacy is a strategy in the attempt to keep down the costs
of the NHS.

4.2 The Rise of Consumerism

The rise of consumerism in health care must also be taken into account. As
patients become more vocal, demanding their 'rights' (without apparently thinking
about the obverse of the rights' coin, i.e. their responsibilities) and as governments
provide structure and process for community input to policy-making (e.g. The
Patients' Charter in the UK and like-minded papers in other countries), the onus for
health care demand is shifting from solely the medical profession. Arguments have
also been mounted that consumer pressure is forcing the practice of defensive
medicine, against the better clinical judgment of the practitioner, thereby increasing
the use of resources, because the clinician will order all possible diagnostic tests to
counter any future allegation of negligence.
The pressure of consumerism has ramifications for health care policy. In order to keep costs down, governments have to keep demand in check. If governments are going to ask the community what it wants in terms of health care provision, administration of policy will not only have to devise methods for obtaining this information, but also devise ways of giving what is demanded, even with diminishing resources. To renege on the provision of requested programs would be politically untenable, but demand will surely outstrip supply. Rationing of some type appears to be inevitable, although as Frankel (1991, p.1589) points out, even if demand may in general exceed supply, this does not necessarily imply that particular health-care requirements cannot be satisfied.

It is much easier for health administrations to blame the medical profession for the excess demand for health care than involve the community in a process of decision-making for rationing procedures to lessen that demand. Politicians, however, have seen fit to put consumer involvement on the agenda, although whether any notice will be taken of consumer input is another question. The hopes of both politicians and administrators for regulating the demand for health care have been pinned on the use of the internal market, but in all countries in which this is being tried, there has been no effort to clearly enunciate the process by which this will occur, nor has there been any attempt by governments to evaluate the results. In regard to the ‘market reforms’ being made to health care systems, Hart (1992) warns that the advocates of the market always deal with episodic care for acute illness and cold surgery, which operate fairly well as services to passive consumers. It is very difficult to translate continuing care and preventive care to commodity
terms. In Hart's view, market competition will restore priority for patients' wants over patients' needs - hardly a desired outcome of the reforms.

5 Prevention: The 'New Public Health'

Given the impetus of the work of the World Health Organisation (WHO), with its Health for All by the Year 2000 agreement, governments are everywhere turning to disease prevention and health promotion as potential cost-effective means to utilise resources. The therapeutic approach to health problems is facing the law of diminishing returns - increased resources devoted to treatment produce progressively smaller increases in health status to populations. This does not stop demand from individual patients, however, who want whatever is available in case it will have some benefit for themselves. Secondly, current clinical practice is limited in dealing with western 'diseases of affluence', which are caused by the environment and unhealthy behaviour and lifestyle. Such diseases require individuals to make changes to their own behaviour and lifestyle. In Australia, the Better Health Commission (1986) advocated the shift towards health promotion in health care policy, but the resources have been minimal at just 1.5% of total recurrent health spending for 1989-90. In the latest figures available for recurrent health expenditures (1990-91), health promotion is not explicitly mentioned. (Australia's Health 1994, p.126)

The chronic conditions of the so-called diseases of affluence have now supplanted the infectious diseases as the cause of 30-40% of western countries' morbidity and mortality statistics. Palmer and Short (1994) have examined the politics of disease prevention and health promotion, and reveal three strategies
which assign responsibility for disease prevention to certain people, and excuse others. The three strategies include the medical approach, the lifestyle approach and the new public health. (See Table 1)

<table>
<thead>
<tr>
<th>Approach Example</th>
<th>Responsible Agent</th>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Doctors</td>
<td>Mammography screening</td>
</tr>
<tr>
<td>Lifestyle</td>
<td>Health Educators/Practitioners</td>
<td>'Quit for Life' program</td>
</tr>
<tr>
<td>New Public Health</td>
<td>Governments, private community organisations</td>
<td>National HIV/AIDS Strategy</td>
</tr>
</tbody>
</table>

Source: Palmer & Short 1994, p.206

The medical approach locates the causes of disease within biology and places primary responsibility for prevention on the medical profession. Lifestyle theory implies that responsibility for ill-health lies with the individual, although the theory acknowledges that not all lifestyle decisions are voluntary. Health educators and practitioners are the agents of change. The ‘new public health’ places the blame on the environment, both social and workplace, and on the captains of industry which produce ill-health inducing products such as tobacco and alcohol. Agents of change are governments, private and community organisations, which should be trying to create healthier environments. The ‘new public health’ approach contends that the imperative of health policy, and public policy generally, should be the creation of an economy, a society and an environment conducive to the production of good health, as distinct from the production of disease. But as Palmer & Short (1994, p.213)
point out, the underlying logic of this strategy would require the transformation of society if it were to be realised fully. Healthy public policies potentially can be found in any sector of government or outside government. Healthy public policy transcends the boundaries of health departments and organisations, and supporters of the notion emphasise that health is a fundamental human right as well as a sound economic investment.

One of the difficulties with designing policy for health promotion and disease prevention is the lack of immediate results from the application of resources. In recessionary times, there is nothing in the health budget to spare for programs which might, in 10 or 20 years time, produce some result, when acute care cannot be adequately funded and the resultant hospital waiting lists cause the prolongation of pain and suffering, not to mention political embarrassment. An economic case could also be made for not funding preventive programs. If preventive care is going to prolong life, diseases of old age will affect more people, simply putting off spending for acute and chronic care until tomorrow. When the life span was around 50 years of age, people didn't live long enough to develop cancers, cardiovascular disease, etc. As for smoking, if policies were to induce people to stop buying cigarettes, there will be fewer taxes collected, and those people will live long enough to become ill with some other disease, thereby incurring costs for the health care system. They will claim pensions, thereby incurring social welfare costs. Should we be trying to save people from their own actions in any case? Should personal risk-taking behaviours be taken into account when allocating resources for health care needs? Why should the care of sporting injuries be paid for out of public funds when personal risk-taking behaviours contributed to the need for health
incurring social welfare costs. Should we be trying to save people from their own actions in any case? Should personal risk-taking behaviours be taken into account when allocating resources for health care needs? Why should the care of sporting injuries be paid for out of public funds when personal risk-taking behaviours contributed to the need for health care? Once again the morality and general philosophies underlying health care policy need to be taken out and given a dusting down every now and then.

Geoffrey Rose, who held the Chair of Epidemiology at the London School of Hygiene and Tropical Medicine until the early 1990s, has coined the term 'preventive paradox' to describe another issue in prevention. (Hofman & Vandenbroucke 1992) The 'patient' of preventive medicine is the population and its health is measured by statistics. Preventive measures aim to improve those statistics. Rose proposed that it is better to change the population distribution of a risk factor rather than target those people at high risk of that factor. The paradox lies in the fact that preventive actions which greatly benefit the population may bring only small benefits for individuals. This is the central issue in comparing the merits of the two main preventive strategies in the medical approach:

1. The high risk approach which aims to detect people at high risk of disease and lower their risk by treatment.

2. The population strategy which aims to shift the whole distribution of a risk factor in a favourable direction.

The high risk approach can be evaluated by randomised trials, but the population strategy is not so easily tested, as it would require changes in lifestyle with any benefits evidenced only decades later.
provide the answers to the problem of apportioning health care resources is not rational. Making health care provision a market commodity, by reducing medical control and government regulation, will solve nothing, yet this concept is behind many of the current reforms to health care systems. [It is interesting to note, however, that in the UK in particular, health ministers have been keen to drop the word 'competition' when speaking about markets in favour of 'contestibility', which merely contains the threat of competition if warranted.] Leeder cites the survey conducted by the Harvard Community Health Plan, which shows that in the USA, people want public health care for everyone at the same time as wanting limitless private health care for themselves and their families. It can be added that they will not countenance increased taxes for the purpose, either.

"Beware the darker side of community perceptions and beliefs, and don't make the mistake of automatically endowing that which is popular in the community with moral dignity." (Arthur Miller, "Timebends", cited in Leeder 1992, p.8)

6. The Uncertainties of Health Care

The problems of definitions as outlined above are exacerbated by the general uncertainties inherent in the health care field, and the reliance on economic theory to provide answers to questions which are of a philosophical nature and which therefore require the application of other fields of endeavour.

6.1 The Uncertainty of Science

Research in the physical sciences is assumed to provide answers because its claims are based on empirical observation, experiments and inductive generalisation, and the scientific method of enquiry distinguishes science from non-science and pseudo science (and, others would add, social science) But as Charlesworth (1982) makes
clear, there are so many methods, all of which can be refuted at least in part, which brings into question the certainty of science. Charlesworth's analysis of the methods of Bacon, Popper, Lakatos, Kuhn, and Feyerabend (for an extreme viewpoint), brings into question the attempts to define science as any bounded spectrum of activities, and whether the physical sciences should occupy the higher moral ground from which its exponents look down on the more qualitative methods of social science. Faith in the ability of 'science' to provide answers to questions which may well be unanswerable is an element in the cost escalation of health care.

"Deep-seated faith plus evidence can make expectations near ungovernable - which might well be connected to the unstemable increase in demand for health services. The great confusion operating in much of modern medical practice today is the failure of professionals and lay persons to confront another inconvenient fact: that in more-or-less equal quantity, there are treatable diseases, there are diseases and human problems for which medical intervention may or may not help, and there are untreatable diseases. Professionals are aware of these possibilities......(but)... it is highly likely that a large proportion of treatments, not to say investigations and referrals, are no more than a face-saving disguise for medical impotence."  (Pickering 1996, p.379)

But as Braithwaite points out:

"The media hyperbole describing medical 'breakthroughs' has seduced people into believing that somewhere there is a cure for whatever ails us, and, given sufficient resources, medicine can cure all our ills." (Braithwaite 1995, p.103)

There are also the social problems which have been 'medicalised' (see Hurowitz 1993), and for which a philosopher (social scientist) is probably required rather than a medical practitioner (physical scientist). Kaye (1988), in discussing the use of psychiatrists for such problems, suggests that philosophical practitioners ought to be available in every hospital and community health care centre.

"For much that is untoward in our lives we need access to a far more appropriate and effective alternative, one that properly addresses our many deep-seated concerns and anxieties, rather than one whose chief tactic is so often simply to prescribe potent medication or drugs. ... An antidepressant or tranquiliser might
by default settle you, but it is not going to settle for you how to best cope with society's injustices or life's apparent futility and meaningless. .. [L]iving is a highly philosophical matter - life is perhaps more significantly problematical in philosophical ways than in any other." (Kaye 1988, p.86)

The public generally has a lack of knowledge about science, and there are misunderstandings of scientific method and the accuracy of clinical prediction. There is lack of understanding about the complexities of biological systems, and the interactions between ethical, medico-legal and socio-political issues, to which there are no right or wrong solutions. Policy makers suffer the same situation:

"The simplistic analyses used by health care purchasers coupled with theories of management, and practice dictates of economic so-called science, together serve to mask the complexities of health care and the uncertainties inherent in human behaviour." (Logan and Scott 1996, p.595)

However, as Turney (1996) points out:

"There is plenty of evidence that past efforts to educate the wider public about science have made virtually no difference, at least in terms of relatively crude indices of 'scientific literacy'."

The laity needs to come to an understanding on the uncertainty of science, and the way in which hypotheses are used in research and theory building. So much of public debate concerns medical issues, specifically medical risks or hazards associated with daily living, e.g. smoking, or treatments, e.g. long term use of oral contraceptives, that it is imperative that policy makers and bureaucrats have enough basic understanding to question certain assumptions and claimed cause-and-effect associations. But some qualitative researchers have pointed out that there is little point in pursuing general efforts to improve the scientific understanding of the general public without considering their specific interests or needs. (See Turney 1996, p1088) They suggest that what is required for science education is a 'bottom-up' approach, which teaches what the people want to know, rather than
the 'top-down' approach which teaches what scientists want the public to know. What scientists see as the public's misunderstandings of science is "not a failure of dissemination but a more fundamental social gap between different forms of understanding and expertise." In fields such as genetics, scientific knowledge is progressing faster than society's ability to keep up with the ethical and moral issues which arise from this new knowledge. As R.H. Brown (1986, pp 119-21) says:

"At the present time our society attaches great value to the practical applications of science and relatively little to its ideas. ..... It is important, I believe, that all of us should have a wider appreciation of the nature of science and that we should not merely be aware, as at present, of its practical uses and abuses. ... in these days of specialized knowledge we cannot expect, nor is it necessarily desirable, that every 'educated' person should know much actual hard science. On the other hand, it is desirable that every 'educated' person should know more about science."

It is doubly desirable that policy makers know more about science, so that they may make more intelligent policy. It is obvious that patients seek out more scientific/medical information from sources other than their medical practitioner. The increase in the use of 'alternative' practitioners, some of whom verge on quackery and many of whom are non-scientifically based, and the patronage of 'health' shops are evidence of this trend. If formal scientific sources cannot provide the information required, perhaps educators should be looking at the problem from the non-scientist's perspective. It is not the general public in need of scientific education *per se* (i.e. scientific knowledge or literacy), it is rather the scientific community in need of evaluating the public's real information requirements. The organisation and provision of health care systems also needs to be explained to the public. At present, many TV soap dramas (especially those emanating from the USA) about hospitals and health care, which rate so highly amongst viewers, are
certainly giving wrong impressions about the reality of health care policy and health care provision. (Turow 1996) [The one exception to date is the British production Cardiac Arrest, which shows the parsimonious NHS in very bad light, although probably close to the truth.] The print media also provides much dubious information to a public which is increasingly unwilling to invest their trust in doctors, scientists and sources of information. Scientific and medical news needs to satisfy two important criteria - journalistic interest and scientific credibility -, but there are increasing concerns in scientific publishing about commercial pressures from pharmaceutical companies, honorary authorship, scientific error and outright fraud, which journalists cannot be expected to detect. (Wilkie 1996)

7. Economics as a Cure for Uncertainty

Given this all-pervasive uncertainty, the rise of health economics as both an academic discipline and an industry in itself should not be surprising. Uncertainty is a most uncomfortable state of being, so the emergent 'science' of health economics, which promised mathematically-precise answers in so many circumstances, was fervently embraced by politicians, policy-makers and administrators everywhere. But as Ormerod (1994) has clearly stated, much current economic theory should be abandoned or at least suspended until it can find a sounder economic base.

"Orthodox economics is in many ways an empty box. Its understanding of the world is similar to that of the physical sciences in the Middle Ages. A few insights have been obtained which will stand the test of time, but they are very few indeed, and the whole basis of conventional economics is deeply flawed. ... Perhaps the most devastating criticisms of conventional economics have come from within the profession itself, from talented and gifted people who have looked deeply into the implications of the assumptions underlying orthodox economics, and in so doing have exposed its limitations on its own terms. ... Good economists know, from work carried out within their discipline, that the foundations of their subject are virtually non-existent." (Ormerod 1994, p.ix)
It is clear from the literature that the assumptions on which economists build their theories, and on which in turn the policy-makers make their decisions, are in the main taken for granted - they appear to have become part of received wisdom, with no need for revisiting. Bearing in mind the ostensible objective of economists is to understand and predict economic behaviour as objectively as possible, then the possibility that economists are building their theories on incorrect assumptions should be a cause for alarm. Keynes’ qualification of the theory of economics appears to be forgotten:

"The theory of economics does not furnish a body of settled conclusions immediately applicable to policy. It is a method rather than a doctrine, an apparatus of the mind, a technique of thinking which helps its possessor to draw correct conclusions." (John Maynard Keynes (1923) quoted in Fuchs (1993, p.2))

As Grossman & Leeder (1994, p.87) note:

"the hope that economics can provide a framework for solving all problems of resource allocation - which is to say almost all problems of health policy and health services management - should be abandoned."

The tendency to place mathematically-precise analyses above the more messy and not so scientifically-proven political and social analyses of problems in the provision of health care is addressed by Somers (1979):

"Economists are far less empirical than is often assumed. The heavy dependence of modern economics on mathematical tools can be misleading. The mathematical models are generally built upon a frail structure of assumptions about human and institutional motivations and behavior. More often than not these assumptions, based upon classical and orthodox economic theory, are invalid for the health field - whatever validity they may have in other economic activities. Few economists have actually undertaken the grimy work of personal observation of organisational structure and behavior of hospitals, how decisions are actually made and by whom, how internal political forces operate, what motivates politicians, etc. Since the foundations of much economic inquiry are so fragile, the conclusions drawn often prove immaterial, and at times even mischievous, no matter how brilliant the superstructure may be."

As one economist who has actually ‘dirtied his hands’, Andreano (1993) has stated:
through preconceived notions rooted in ideology?" The question of the physician's power to induce demand is cited by Reinhardt as an example to show this ideological bias in action. Economists fall into two camps, the 'broad economists' (the Bs) and the strict adherents to the neo-classical school, the 'narrow economists', (the Ns) The Bs take for granted the physician's power to induce demand, at least within limits, a phenomenon referred to as the 'volume problem'. The Ns maintain that physicians will not, or cannot, induce demand in response to greater economic pressure. The ideology underlying these opposing views needs to be clearly spelled out, so that policy makers are aware of the foundations upon which economic theories are built. The advice offered by the two sides would result in different policies for any given issues, e.g. physicians' fees. We need to know the factors on which these economic models are based. As Reinhardt (1989, p.338) points out, models are often based on the imagery of uninsured well-patient care, whereas in fact about 75% of all health expenditure (in the USA) in any given year, is accounted for by only about 10% of the population. These patients are likely to be quite sick, well insured and in the care of physicians who are compensated on a piece-rate basis, by distant third parties. Reinhardt finds it hard to disagree with Pauly's (1988) remark that

"for many reasons it is likely that we [economists] will never fully resolve the demand creation/information imperfection question. ... Thus the fee-for-service market will remain a mystery as far as empirical predictions are concerned."

In Reinhardt's opinion, the issue of physician-induced demand obviously goes straight to the heart of probably the major controversy in contemporary health policy (in the USA), namely, the question whether adequate control over resource
allocation to and within the health care system is best achieved through the demand side, by letting consumers (patients) discipline providers who compete against each other on the basis of quality and price, or through regulatory controls on the supply side. The choice between these two options is not distributionally neutral. Economists recommending one or the other therefore engage in overtly normative policy analysis. Normative health economics

"is so fraught with potential abuse (if only through thoughtless use of technically precise terms...), that one must wonder whether economists as social scientists ought to engage in it at all. If they do, they should be ever mindful of society's concern over distributional equity, which does set health care apart from most other commodities. 'Greater efficiency' in abstraction from that concern is simply an oxymoron." (Reinhardt 1989, p.341)

Thomas Rice is another who queries the underpinnings of economic theory, and suggests alternative frameworks based on medical effectiveness research. Rice (1992) contends that the traditional method of calculating excess losses from health insurance is severely flawed, suggesting that empirical evidence indicates that consumers do not behave in the way in which economic theory predicts. Rice (1993) argues against the economic wisdom that says that the medical care demand curve is an appropriate measure of the value that consumers place on medical care spending, saying that there is much reason to believe that a demand curve does not accurately reflect consumer utility.

"The assumptions upon which this belief rests - such as good consumer information and a(n) homogeneous product - are not fulfilled in the medical care market. The fact that a demand curve exists only indicates that consumers are forced to make choices about the amount and types of services to purchase. It does not validate their choices. If the choices they make are bad ones, then the demand curve simply represents the amount people are willing to purchase, not what their purchases are worth to them." (Rice 1993, p.202).
While Ormerod castigates economics in general, eminent health economists such as Ewe Reinhardt (1989) mentioned above, Rashi Fein (1994), Victor Fuchs (1993b) and Robert Evans also warn about the assumptions underlying health economics and have cautioned health care policy-makers against the unequivocal acceptance of their discipline's tenets.

The management of health care systems and the reforms undertaken during the last decade have been based on economic models which have been criticised for their narrowness and the social and economic assumptions on which they are based, as well as the quasi-scientific quantitative techniques employed. As for the reforms based on the concept of the market-place, Carr-Hill (1994a, p.1196) takes to task researchers who think reforms should be

"Based on a naive presumption that markets will function more or less as theory dictates. Yet time and again, evidence suggests the opposite."

The discipline of economics has been seen as a framework for solving all problems associated with health policy and health services management. (Grossman & Leeder 1994) This false hope should be abandoned and the problems viewed in terms other than funding and technical efficiencies. By focusing on funding and efficiency to the exclusion of all else, managers have allowed themselves to be seduced by the promise of technical solutions, such as QALYs and cost-utility analysis. There must be attention paid to ethical, philosophical and moral questions, particularly in the area of resource allocation and the rationing of services.

We can no longer (indeed could we ever) afford the economic concept of ceteris paribus in health care policy, because the assumption that all things other than that which is being measured are equal is not valid. Nor can we any longer
afford the medical concept of *primum non nocere*, first of all do no harm, as there are insufficient resources to allow the use of every medical intervention as long as it does no harm. Practitioners of both health economics and medicine must change their attitudes, assumptions and practice, to meet the new realities of health care provision. And patients must change their expectations of magic bullets and wonder cures for all ills which afflict humanity, accepting that death from disease states is inevitable at this stage of humanity's evolution. They must also accept the fact that there is a limit to medical treatments and health care resources, especially when those resources come from the public purse. [A current and topical example is the woman who expected to receive a publicly-financed surgical procedure to reverse her tubal-ligation sterilisation. She already has five children, four from a previous marriage and one from her current marriage, and now wants another child. She intends to sue the public hospital because she has been told that the reversal procedure is no longer available under the public scheme, because of changes to criteria for allocation of resources, and she will now have to pay for it herself. Reported in *The West Australian* 5 October 1996, pp1, 3]

The behaviour of decision-makers must be changed, but this is a complex task. Maynard & Bloor (1995, p.253-4) outline problems at macro and micro levels. At the macro level, the policy problem is compounded by the fact that health care expenditure is revenue for health care providers, so any attempt to rein in costs threatens incomes and jobs in hospitals, the pharmaceutical industry, medical professions and insurers. The response to the Clinton Health plan by insurers was to spend US$250-300 million on countering the proposed legislation. Policy problems at micro-level include the point that we do not know which interventions are cost
effective, the fact that fee-for-service probably induces over-production, (although capitation probably induces less-than-optimum care) and that self-regulation is an essential input into medical care.

Changing professionals' behaviour in one area may produce unintended consequences in other areas. Professional activity which is governed by duty may be more cost-effective than the creation of bureaucratic regulation in public and private markets. Clinical autonomy may well provide better quality care than imposed guidelines for practice, utilisation review and quality control measures.

8. Conclusion

The problems of definitions covered in this chapter give rise to different viewpoints and perspectives of policy makers who have to grapple with many of the problems listed in Box 5 (macro level), Box 6 (meso level) and Box 7 (micro level) in Diagram 1. At the macro level, how these issues are perceived will lead to decisions on how much GNP will be voted to health care and also how the systems will be organised. At the meso level, decisions on area needs will be influenced by perceptions of different groups of people (e.g. the aged, youth, disabled) and of preventive measures. At micro level, decisions which will affect individual patients will be influenced by the perceptions of medical personnel on many of the issues discussed. Affecting these issues, perceptions and decisions will be those factors enumerated in Box 8 in Diagram 1, that is availability of information, reliability and validity of evaluation techniques and the major problem of health care systems today: equity or resource allocation versus cost effectiveness.

If we need to accept public input with caution, then there is even greater need to treat economic theory in the area of cost effectiveness cautiously, for it is
the theoretical incoherence from this subject area which contributes to the 'systemic intellectual incompetence' mentioned in the opening quotation of this Chapter. There is also the lack of coordination between economic policies and health care policies as outlined by Watt (1996). Davey-Smith (1996, p.988) cited in a BMJ editorial the growing evidence that income inequality is "bad for the economy, bad for crime rates, bad for people's working lives, bad for infrastructural development and bad for health" - in both the short and long term, but government continues to pay no heed. Economic theories underpinning fiscal and monetary policies continue to exacerbate the problem of growing unemployment, thereby increasing the need for health care. Governments need to have the 'big picture' continually in sight, so that there can be a coordination of these policy areas. Included in this big picture will be clear definitions of terminology within health care policy, and assumptions underlying different perspectives will be debated, so that there is no ambiguity. There must be concerted attempts to lessen the confusion and theoretical incoherence in health care policy making.
Chapter 3. OBJECTIVES and ORGANISATION of HEALTH CARE SYSTEMS

1. Objectives of Health Policy and Health Care Policy

The major normative objective of health policy in industrialised nations is recognised as the need to maximise the health status of a country's population. The major objective of health care policy is to maximise the value obtained from the allocation of health care resources in accordance with the tenets of equity and social justice, which may vary from society to society. The strategies to attain these objectives include the funding and provision of health care services to provide for treatment and rehabilitation of those already sick and injured, preventive measures to try to stem the occurrence of ill-health and accident, and health promotion programs to help individuals attain and keep good health status. There are so many choices within these broad strategies, however, as to guarantee complexity and confusion. The 'medicalisation' of large areas of health policy has seen priority given to the treatment of short-term acute illness, to the detriment of adequate funding for the care and rehabilitation of the chronically ill. (Hurowitz 1993; Mechanic 1993, 1995) The reality of health policy in most Western countries over the last two decades has been a focus firstly on the mechanisms for funding health care systems and secondly on their reorganisation, with little attention being paid to the variations in health status between different socio-economic groups within a single country and the needs of these groups. Policy focus on arresting the cost escalation in health care and the concentration on inputs to the health care provision process has taken precedence over basic issues such as inequities in access to health care, the quality of that care, patient needs assessments and the realisation that
rationing of health care provided by public means is now a policy priority. The need for a ‘big picture’ approach to health care policy is growing more urgent, as the narrow focus has caused cuts in health programs which ultimately impact on other areas of policy. The last five years have seen a shift in focus, as it has become increasingly obvious that more resources for health care does not necessarily mean better health outcome, and not only must health care systems change, so must the practice of medicine at the clinical level. Reforms to health care systems at the micro level are beginning to focus on outcome measures and evidence-based medicine, so that the treatments which are resourced are those which are most effective. The practical realities of changes to the practice of medicine include the perceived loss of clinical autonomy and a threat to the maintenance of quality of care. According to OECD research, the organisation of health care systems in the Western world centres around the three goals which most governments pursue in the health care area, that is equity, micro-economic efficiency and macro-economic cost control.

A. Equity:

"Citizens should have access to some incompressible minimum level of health care, and treatment should be based on need for care rather than solely on income. Further, individuals should be offered some degree of protection against the financial consequences of falling ill, and payment for this protection should be income-related rather than based on individual risk." (OECD 1994b, p.5)

Once again, the problems of definition as discussed in Chapter 2 confront policy makers, including how to define ‘minimum level of care’, and ‘need’. The form of protection which is to be offered to individuals must also be decided, and it may be either private or social insurance, income transfers or public supply, or indeed a mixture of these approaches.
B. Micro-economic efficiency:

This objective means that "quality of care and consumer satisfaction should be maximised at minimum cost. Micro-efficiency also requires taking into account 'spill-over' effects (e.g. due to communicable diseases and productivity-related effects on the labour force.) Dynamic efficiency considerations include searching for organisational forms and technological advances that improve the productivity of health resources. More broadly, in assessing the most efficient ways to improve health 'outcomes' (or health status), governments need to consider whether increased resources channelled into mainstream health services are not draining resources from other, more effective programs (e.g. housing, education, income maintenance, nutrition and hygiene, all of which will influence a nation's health)." (OECD 1994b, p6.)

There are two aspects to this objective which must be taken into account by policymakers: productive efficiency which is associated with producing a fixed set of services at minimum cost; and effectiveness, defined as maximising services provided for a fixed set of inputs, or maximising the impact on health goals, defined as the length and quality of life. Costs ought to include administrative expenses which can vary enormously between different health care structures. (Himmelstein & Woolhandler 1986; Woolhandler & Himmelstein 1991; OECD 1994b, p.76)

Other major problems with this objective centre around the meaning of 'quality', and the concept of patients-as-consumers. What standard of quality is acceptable, and to whom? The asymmetry of knowledge of patients does not empower them to act as consumers of health care as they would for other goods and services. This problem has been exacerbated in those countries where 'patients charters' have been introduced. Another problem relates to the search for technological advances, which are often held responsible to a large extent for rising costs. Many technological advances do reduce the cost of many treatments; however, they also permit more of those treatments over the same time-scale, so the total cost will be greater.
C. Macroeconomic cost control:

Macroeconomic cost control means that “the health care sector should consume an ‘appropriate’ share of GDP. Although there is no necessary reason to restrain the level of spending simply because it is high or growing rapidly, spending limits can become desirable where government policies or private market failure lead to excess supply or demand for health services.” (OECD 1994b, p.6)

Problems for policy-makers are those discussed earlier, including the meaning of ‘appropriate’ share, and the definition of ‘excess’ supply or demand.

Ultimately, the objectives of a health care system are decided by the various stakeholders, whose viewpoints policy-makers must take into consideration when deciding on

i) the different types of care required by a population, e.g. curative, preventative, rehabilitative, acute, chronic, continuous or episodic;

ii) the amount of care available within various settings, e.g. primary, community, hospital (various levels); and

iii) the placement of these different institutions within geographical boundaries.

There are issues concerning the prioritisation of need amongst various disease entities, screening programs, etc. Then there are the issues of education and training of both current and future providers of care, which lead to facilities and manpower planning policies. The lead time required for the training of a clinician is ten years, so ‘manpower planning’ is probably oxymoronic, given the probability of rapid change in that time. Technological advances can make facilities planning obsolete before any building takes place. One example is the need for day surgery facilities and the reduction in the number of hospital beds. Research and its funding especially within teaching hospitals, and the dissemination of information and of
new knowledge are issues germane to the continuance and quality of medical care. How much innovation can be afforded? How much is necessary to produce advances in knowledge? How much risk can be taken to enable innovation and therefore ensure future benefits? These issues engender conflict between the two goals of equity and efficiency and proposed resolutions of problems may well have unforeseen consequences.

There are various ways in which health care systems may be organised to help attain these objectives and the following section discusses 3 typologies of systems.

2. Typologies of Health Care Systems

The difference between ‘health system’ and ‘health care system’ must be noted. As commonly used, the latter is a narrower concept, restricted to the providers, resources and the state. The current reforms show a transition towards the broader concept, which includes all the actors in health systems and the multi-sectorial actions and relationships within the system. In typologies of health care systems, ‘systems’ is used in the sense of ‘relational’, thus they include the components and their relationships - providers, population, the state and its defined role, organisations which generate resources and other sectors which produce services with health effects. Systems must share a common objective, and it is this that is changing - health care systems include various stakeholders who have different aims and objectives, as discussed in Chapter 1.

Following are three typologies of health care systems from the literature: Field (1989), Roemer (1992) and Elling (1994). Field classifies systems into 5 different types which range from the perspective that health care is seen as an
individual responsibility (Type 1 Emergent) through degrees of market/social security mix (Types 2, 3 and 4) to the fully-fledged socialist system of Type 5.

Each type is analysed to provide the descriptors of:

- position of the provider - e.g. from solo entrepreneur to state employee;
- the role of the professional associations, as being either powerful/strong or weak/nonexistent and degrees in between;
- the ownership of the facilities;
- how providers are remunerated;
- the role of the state in the provision of care; and
- the countries which fit into each type of system.

Using Field's typology, Australia, New Zealand and Canada are placed in the middle Type 3, an insurance/social security-based system, the USA in Type 2 (pluralistic system) and the UK in Type 4, i.e. a national health system.

Roemer (1992) uses the two dimensions of economic level and health systems policies, each scaled to four steps, to make a matrix of 16 cells. (Figure 8)

Theoretically, the health system of every country in the world would fit into one of these 16 cells. He points out that this is time-contextual, and the figure relates to the late 1980s. Also, as in any scaling, countries may well be borderline cases along both dimensions. With competition-based reforms, some countries are migrating towards the entrepreneurial and permissive/affluent and industrialised cell. The USA has been trying to move toward the universal and comprehensive cell. As Roemer notes, however, placing a country in its appropriate cell can help with an understanding of many aspects of its health care system, and such knowledge can be helpful in providing perspectives on problems encountered.
<table>
<thead>
<tr>
<th>Health System</th>
<th>Type 1 Emergent</th>
<th>Type 2 Pluralistic</th>
<th>Type 3 Insurance/ Social Security</th>
<th>Type 4 National HS</th>
<th>Type 5 Socialised</th>
</tr>
</thead>
<tbody>
<tr>
<td>General definition</td>
<td>Health care as item of personal consumption</td>
<td>Health care as predominantly a consumer good/service</td>
<td>Health care as an insurance guaranteed consumer good/service</td>
<td>Health care as a state-supported good/service</td>
<td>Health care as a state-provided public service</td>
</tr>
<tr>
<td>Position of physician</td>
<td>Solo entrepreneur</td>
<td>Solo entrepreneur and member of variety groups, organisations</td>
<td>Solo entrepreneur and member of medical organisations</td>
<td>Solo entrepreneur and member of medical organisations</td>
<td>State employee, member of medical organs'ns</td>
</tr>
<tr>
<td>Role of professional associations</td>
<td>Powerful</td>
<td>Very strong</td>
<td>Strong</td>
<td>Fairly strong</td>
<td>Weak or non-existent</td>
</tr>
<tr>
<td>Ownership of facilities</td>
<td>Private</td>
<td>Private &amp; public</td>
<td>Private &amp; public</td>
<td>Mostly public</td>
<td>Entirely public</td>
</tr>
<tr>
<td>Payments</td>
<td>Direct</td>
<td>Direct &amp; indirect</td>
<td>Mostly indirect</td>
<td>Indirect</td>
<td>Entirely indirect</td>
</tr>
<tr>
<td>Role of the polity</td>
<td>Minimal</td>
<td>Residual/ indirect</td>
<td>Central/ indirect</td>
<td>Central/ direct</td>
<td>Total</td>
</tr>
<tr>
<td>Countries</td>
<td>USA</td>
<td>Canada</td>
<td>New Zealand</td>
<td>Australia</td>
<td>UK</td>
</tr>
</tbody>
</table>

Source: After Field (1989, p.7)

"Any strategies for system changes can be formulated with greater assurance, if done in light of experience in other countries of the same type." (Roemer 1992p.97).

This opinion may be somewhat optimistic, given Roemer's typology is based on only two dimensions, both of which are economics-based. The market intervention dimension is but one of many political/economic factors to be taken into account. The four types of system by type of market is useful, however, when comparing funding and provision elements of health care systems.
Figure 8 Roemer’s Typology of Health Systems classified by economic level and health systems policies (market intervention)

<table>
<thead>
<tr>
<th>Economic Level (GNP per Capita)</th>
<th>Market Intervention Continuum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Entrepreneurial &amp; Permissive</td>
</tr>
<tr>
<td>United States</td>
<td>Australia</td>
</tr>
<tr>
<td>Canada</td>
<td>New Zealand</td>
</tr>
<tr>
<td>Affluent &amp; Industrialised</td>
<td>Japan</td>
</tr>
<tr>
<td></td>
<td>West Germany</td>
</tr>
<tr>
<td></td>
<td>Belgium</td>
</tr>
<tr>
<td></td>
<td>France</td>
</tr>
<tr>
<td></td>
<td>Netherlands</td>
</tr>
<tr>
<td>Developing &amp; Transitional</td>
<td>Thailand</td>
</tr>
<tr>
<td></td>
<td>Philippine</td>
</tr>
<tr>
<td></td>
<td>South Africa</td>
</tr>
<tr>
<td>Very Poor</td>
<td>Ghana</td>
</tr>
<tr>
<td></td>
<td>Bangladesh</td>
</tr>
<tr>
<td>Resource-rich</td>
<td>Libya</td>
</tr>
<tr>
<td></td>
<td>Gabon</td>
</tr>
</tbody>
</table>


Elling (1994) has suggested a schema deriving from theory of the capitalist political economic world-system, in contrast to the typologies of Roemer and others “which offer no apparent theoretical derivation.” Elling views Roemer as assuming that most countries are converging in a more socialised, planned direction, and views
others such as Field and Mechanic as assuming a convergence of increasing specialisation, complexity and higher costs. Elling views others such as Fuchs, as assuming elements of change such as the technological imperative, and he thinks that these convergence theorists miss or remove the "very key element of human struggle, particularly class struggle in the development of health systems."

"In addition to highlighting the element of class struggle, an adequate health systems framework and typology should reflect the major dimensions related to the likelihood of achieving health for all (HFA) and primary health care (PMC). Thus the preconditions of social and economic justice and wide citizen participation involved in determining health conditions and service should be reflected with reference to the strength of the workers' and peasants' movement, and with the struggle for human rights and democracy in general." (p.288)

Elling criticises many authors of comparative studies of health care systems for lacking a rationale for their selection of health systems; what he is presumably attacking is the lack of political elements, and in particular the comparative strengths of workers' movements as a major factor. He rightly points out (p.305) that the debate over health care reform in the USA is focused on funding sources, costs and coverage, while organisational forms are ignored (or avoided). Elling's 'working' typology is framed in a Marxist analysis, and includes all countries, developed and developing. His framework has three perspectives derived from the division of labour - core, periphery and semi-periphery - combined with the strengths of labour movements to give five types of health systems. His suggested classification is, like Roemer's, dynamic in that systems are moving or verging on movement from one category to another. Elling's categories move from core capitalist, such as USA, where the health system is market oriented, through core capitalist (social welfare) which describes Canada, UK, Sweden and Japan (the latter may also fit into core capitalist), industrialised socialist-oriented (originally
describing communist Europe), capitalist dependencies in periphery/semi-periphery, such as India and elsewhere where there are ‘obscene’ social and economic as well as health disparities, and finally socialist-oriented, quasi-independent of world system category which includes China.

2.1 Comparison of Typologies

There is no disagreement with Elling on his statement that, “while nation states remain the most appropriate units for the comparative study of health systems, they cannot be understood independent of their position in the capitalist political economic world system”; but it is doubtful his insistence on class struggle as being the primary dynamic for change will be agreed by all observers. The problem with typologies such as Roemer’s and Elling’s is the comparison of systems in countries which have such disparate political systems, usually also reflected in the dichotomy of developed and developing, or industrialised and non-industrialised countries. Elling’s typology places Canada and the UK together, and Australia would have to fit in here also. New Zealand would have to be placed in the core capitalist category with the USA, and this clearly misrepresents the situation. Roemer’s typology, while categorising in much the same way as Field, does not, at this stage of development, break down into small enough elements to be of use for comparative purposes. Field’s typology, on the other hand, is useful for comparing Australia, Canada, USA, New Zealand and UK. These countries can be compared and placed at points along a continuum for all the elements analysed. Their overall placement on a continuum from emergent to socialised health care systems is indicative of the convergence amongst these countries to the middle ground. The reform attempts in the USA are trying to move the country from a pluralistic health
care system and towards an insurance-based social security system; the reforms in the UK are moving towards this middle ground also, but from the opposite direction. Australia, Canada and New Zealand already occupy this middle ground, as shown in diagram form (Diagram 2) below.

<table>
<thead>
<tr>
<th>Pluralistic</th>
<th>Insurance/Social Security</th>
<th>National Health System</th>
</tr>
</thead>
<tbody>
<tr>
<td>USA ---&gt;</td>
<td>Australia, Canada, NZ</td>
<td>UK</td>
</tr>
</tbody>
</table>

Using Field's typology, it can be seen that, in order for the reforms in the USA to have the desired effect, health care must be viewed less as a consumer good or service, and more as an insurance-guaranteed good; the role of professional associations need to be weakened; fewer direct payments should move the reimbursement structures toward indirect payments, and the role of the polity must become more centralised. The philosophies underpinning the USA's pluralistic system will need to undergo change before health care reforms will succeed. In the UK, on the other hand, reforms did not have to make such severe changes, and the role of the polity, already centralised, ensured enactment of the required changes - a situation in complete contrast to the USA.

3. Structural Components of Health Care Systems

Health care systems are comprised of funding mechanisms, organisational arrangements and delivery considerations, each of which will be considered below. In terms of providing free health care to their citizens, countries may organise their health care system in one of two ways. Firstly, the health care may be provided by
the state, in which case the system is a national health care service (e.g. UK); or the state may provide insurance cover to all in case of illness, in which case the system is termed a national health care insurance scheme (e.g. Australia). The USA on the other hand provides a mixed system with some free or low-cost care provided to specific groups, but most care is funded through employer-based insurance in a free-market system.

a) Funding Mechanisms

Funding has two parts:

1. The revenue-collecting mechanisms, such as taxes, levies, insurance and patients payments (termed 'co-payments' or 'out-of-pocket' payments).

Institutional arrangements for the revenue-collecting part of funding include finance/Insurance systems which may be of the following types:
   i. Private insurance
   ii. Social insurance
   iii. Tax Finance
      - population covered
      - risks covered
   iv. Co-sharing by patients

2. The reimbursement mechanisms, which involve the transfer of revenues to hospitals, other institutions and health care providers. Reimbursement mechanisms for funding hospitals include the following:(for a full description see OECD 1994b, Box E p.38)
   i) Block Grants or Global Budgets, which provide a direct means of containing hospital spending.
   ii) Bed-Day Payments, which provide hospitals with a flat-rate fee per occupied bed.
   iii) Fee-for-Service, which pays hospitals according to individual services provided. Under this system, macro-control is weaker (requiring spending to be contained by other means), with suppliers facing incentives to raise the quantity, quality and prices of services provided.
   iv) Payments-per-Case, a method which sets fees prospectively according to diagnosed medical conditions and standardised treatment costs. The best-known system is the Diagnostic Related Groups approach (DRGs) introduced into the U.S.
Medicare program in 1983. These methods come closer than those above to being output-based payments, hence facilitating competitive contracting for treatments, and constraining suppliers' incentives to increase service volumes. They provide incentives to hospitals to increase turnover (i.e. reducing lengths of stay) but may lead to some 'unbundling' of hospital services, and there is a risk that hospitals may, where possible, 'bump' patients into more highly remunerated diagnostic groups (DRG-creep).

Reimbursement to clinicians and individual includes the following mechanisms: (for details see OECD 1994b Box F, p.42)

i) Salaries, generally negotiated centrally (e.g. between physicians' associations and the government), with individual-based adjustments sometimes included to allow for experience, location, and other reward and/or incentive considerations.

ii) Capitation Payment, which provides GPs with a fixed payment, usually with adjustments for factors such as age and gender for each patient on their 'list'. This system is used in the UK, with some fees and allowances for specific services. Capitation systems allow funders to control the overall level of primary health expenditures.

iii) Fee-for-Service, as used to pay GPs in Australia, Canada, New Zealand and USA. It is also the usual method by which specialists are paid in most countries. Fee levels are either negotiated centrally (Canada, New Zealand) or by state (Australia) or by individual practitioner. Some countries (e.g. Australia and New Zealand) allow 'extra billing' by GPs on top of standard patient reimbursement rates.

b) Organisational Arrangements

Health care systems are usually organised in two distinct parts:

1. Personal Medical Care (or Ambulatory Services)

Personal medical/health care is provided by General Practitioners (GPs) or Family Medicine Practitioners (FMPs) and other allied health professionals, and medical specialists in their own surgeries, in outpatient departments, clinics, etc., and for comparative purposes is called 'outpatient' care.
2. Hospital Treatment

This type of care is classified as institutional, or inpatient, e.g. hospitals, nursing homes, etc., although sometimes day surgery is included as hospital treatment. These two organisational parts will have different structures, processes and funding mechanisms which complicate still further the management of health care systems. It will be seen that where the two parts are funded by different levels of government or sectors of the industry, cost-shifting will be attempted where the structure is loose. For example in Australia, personal medical care is funded by the Commonwealth government via the national insurance scheme Medicare, which pays practitioners via bulkbilling and reimburses patients who choose to pay their doctor’s account first then apply for reimbursement. Hospital care is federally funded but mainly operated by the states. Hospitals which provide an out-patients department for example, could save the state some health care costs (i.e. those paid out of state budgets) if patients were dealt with by local general practitioners instead, thereby shifting the costs to the Commonwealth’s ambulatory/personal care Medicare system. The federal government deems this type of activity to be illegal, but state governments, especially when of a different political persuasion to the federal, deem it to be not only legitimate but obligatory wherever possible.

The task of developing an optimal structure for a health care system will be impossible until several obstacles are overcome:

i) Consensus is required on the relative importance of the three major goals of health care systems: universal and equal access to reasonable health care; control of health care costs to a reasonable level; and effective use of resources.
Socioeconomic and political goals and objectives must be clarified before consensus on relativities of the major health care goals can be gained.

ii) The opposing ideologies of free enterprise (market) versus government planning and intervention (regulation) need to be discussed and a balance agreed. As Hsiao (1992) remarks, this long-running debate has impaired rational discussions on the best approach to structuring a health care system, and points out that in redefining the economic doctrine in the health care context, the debate is between the demand-side and the supply-side approaches. Hsiao's remarks reflect the chaotic US scene, but the other countries are continually trying to balance the tensions inherent in this dichotomy.

iii) The usual state is one of inadequate knowledge and insufficient empirical information. We need to know how the various systems perform, and the key dynamic forces that influence outcomes.

Hsiao recommends a comparison of the performance of health systems based on demand-side theory with those based on a supply-side approach to provide information about various outcomes of the various systems. The goal is to understand better the key factors that affect one's own health care system. This would help overcome the last obstacle.

3.1 Expenditure in Health Care Systems

Expenditure is classified into the two major categories of personal medical care (ambulatory services) and hospitals, but sub-categories of these are used also: pharmaceutical services and the long-term care institutions such as nursing homes. Also to be taken into account in terms of resource allocation and costing is research & teaching, which is usually carried out in tertiary level hospitals. Political factors,
reflecting the various strengths of lobby and interest groups, determine allocation of resources across these subcategories.

Primary care doctors (GPs) are usually the first port of call for patients in the ambulatory care section of the health care system, except in the USA (Pingitore 1993; Starfield & Simpson 1993), and are the formal or informal gatekeepers for the secondary and tertiary sectors. (Grumbach & Fry 1993; Hannay 1993; Malcolm 1994; Maynard & Bloor 1995a; Whitcombe & Desgroseilliers 1992; Wright 1993)

Costs are difficult to control in ambulatory care especially in those systems where there is no patient fee involved to restrain unnecessary visits to the doctor. GPs have to be relied upon to maintain high quality of care without unnecessary expenditure of resources. Where GPs are paid by fee-for-service, there is the incentive to over-service, especially where scheduled fees are perceived to be too low. Where GPs are paid by capitation, there is the incentive to under-serve and to pass on too quickly patients to specialists. Where GPs are fundholders, they are both providers of primary care and purchasers for secondary care and pharmaceuticals for their patients. Here again mixed systems of remuneration may prove beneficial in removing the negative incentives under pure remuneration schemes.

OECD countries differ widely with respect to how total health expenditures are divided between major subcategories of in-patient care, ambulatory care and pharmaceuticals. But the boundaries between these subcategories are not always clear and allocation methods are not standardised across countries. Table 2 shows expenditure on the subcategories of health care systems in the five countries.
Table 2  The Structure of Expenditure on Health 1970-1990
Share of the major subcategories in total expenditure, in percentages

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>44.1</td>
<td>26.8</td>
<td>11.8</td>
</tr>
<tr>
<td>United Kingdom(1)</td>
<td>49.0</td>
<td>...</td>
<td>...</td>
</tr>
<tr>
<td>Canada</td>
<td>52.2</td>
<td>22.4</td>
<td>11.2</td>
</tr>
<tr>
<td>Australia</td>
<td>29.1</td>
<td>...</td>
<td>...</td>
</tr>
<tr>
<td>New Zealand</td>
<td>55.7</td>
<td>...</td>
<td>...</td>
</tr>
</tbody>
</table>

Hosp. refers to in-patient care; Amb. to all out-patient medical and paramedical services; Pharm. to the purchase of medicines including over-the-counter or self-prescribed medicines. Columns do not add to 100 because certain elements are excluded, e.g. therapeutic appliances, central services, administrative costs, R & D and investment.

(1). The in-patient care ratios refer to publicly funded care only.

Source: OECD 1994(b), p.73

Within these subcategories, divisions occur between teaching and community hospitals; specialists and generalists; scheduled drugs and non-scheduled drugs (causing inequities) and the problem of funding for research and teaching functions.

3.2 Differences in Spending levels

Spending on health care per capita varies widely across countries. There may be some degree of international convergence towards an income-dependent 'spending norm' for health, but there can be no strict causal relation between health-care spending and GNP because the mechanisms determining the level of health spending in individual countries are complex, encompassing both supply and demand variables as well as decisions of a public choice nature. (OECD 1994b, p.19)
Table 3 shows per capita health expenditure and per capita GDP spending in the five countries for 1987.

<table>
<thead>
<tr>
<th>Country</th>
<th>Health Expenditure</th>
<th>GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>$ 939</td>
<td>$12,612</td>
</tr>
<tr>
<td>Canada</td>
<td>1,483</td>
<td>17,211</td>
</tr>
<tr>
<td>New Zealand</td>
<td>733</td>
<td>10,680</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>758</td>
<td>12,340</td>
</tr>
<tr>
<td>United States</td>
<td>2,051</td>
<td>18,338</td>
</tr>
</tbody>
</table>

**Note:** Amounts are denominated in US dollars using GDP purchasing power parities. Source: Schieber & Poullier (1990, p.12)

There are large differences beyond what might be expected on the basis of income, e.g. the US spends substantially more while the UK spends substantially less. Cross-country comparisons of health-care spending per capita confirm the importance of income, but point also to a variety of other factors. Alternative ways of supplying and pricing health care, differences in underlying institutional arrangements and associated incentive structures, e.g. the use of gatekeepers to the more-expensive hospital system; fee for service versus capitation remuneration, etc. The following Tables show, firstly, total health care expenditure as a percentage of GDP and secondly, health status measures for the five countries.
Table 4
Total Expenditure on Health Care in GDP, 1960-1992
Per cent of GDP

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>5.3</td>
<td>7.4</td>
<td>8.4</td>
<td>9.2</td>
<td>10.5</td>
<td>12.4</td>
<td>14.0</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>3.9</td>
<td>4.5</td>
<td>5.5</td>
<td>5.8</td>
<td>6.0</td>
<td>6.2</td>
<td>7.1</td>
</tr>
<tr>
<td>Canada</td>
<td>5.5</td>
<td>7.1</td>
<td>7.2</td>
<td>7.4</td>
<td>8.5</td>
<td>9.4</td>
<td>10.2</td>
</tr>
<tr>
<td>Australia</td>
<td>4.9</td>
<td>5.7</td>
<td>7.5</td>
<td>7.3</td>
<td>7.7</td>
<td>8.2</td>
<td>8.8</td>
</tr>
<tr>
<td>New Zealand</td>
<td>4.3</td>
<td>5.2</td>
<td>6.7</td>
<td>7.2</td>
<td>6.5</td>
<td>7.3</td>
<td>7.7</td>
</tr>
</tbody>
</table>

Source: OECD 1994b, p.60

Table 5
Health Status and Outcome Indicators, 1992

<table>
<thead>
<tr>
<th></th>
<th>Female Life Expectancy</th>
<th>Male Life Expectancy</th>
<th>Female Life Exp at age 60</th>
<th>Male Life Exp at age 60</th>
<th>Perinatal Mortality (1)</th>
<th>Infant Mortality (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>79.0</td>
<td>72.3</td>
<td>22.9</td>
<td>18.7</td>
<td>0.87</td>
<td>0.85</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>79.0</td>
<td>74.0</td>
<td>22.0</td>
<td>17.7</td>
<td>0.81</td>
<td>0.66</td>
</tr>
<tr>
<td>Canada</td>
<td>80.4</td>
<td>73.8</td>
<td>23.7</td>
<td>18.9</td>
<td>0.77</td>
<td>0.68</td>
</tr>
<tr>
<td>Australia</td>
<td>80.4</td>
<td>74.5</td>
<td>23.4</td>
<td>19.1</td>
<td>0.94</td>
<td>0.70</td>
</tr>
<tr>
<td>New Zealand</td>
<td>78.7</td>
<td>72.8</td>
<td>22.5</td>
<td>18.4</td>
<td>0.74</td>
<td>0.73</td>
</tr>
</tbody>
</table>

(1) Deaths in the first week of life as a per cent of live and stillbirths
(2) Deaths of children aged 1 year or less as per cent of live births

Source: OECD 1994b p.71

c) Delivery: The Management of Health Care Systems

An overriding trend during the last decade has been the move towards a more
'managerial' style in administering the policy process, and this in itself has helped
shape the policy change. In health care, the managerial approach required a detailed
knowledge of what health care providers and hospitals actually did in terms of
patient outcomes. This requirement necessitated changes to the ways in which health care provision was perceived, so that valid indicators could be formulated and quantified. New computerised information systems were required to accumulate the data needed. The old input/output method of calculating and evaluating medical and health care was no longer adequate, and the new 'outcomes'-oriented data produced an environment in which policy planners had to come to terms with the fact that some of the existing health care policies were not producing the desired results. The new managerial reforms in public administration have restructured the provision of health care in all the countries under scrutiny, and have brought new problems in their wake. At the root of all these problems is the need for the equitable allocation of scarce resources among the competing wants of the members of any given society.

Reforms have been instituted at each of the policy levels in health care systems. Change in any situation alters the status quo, changing the locus of power and at times turning current winners into losers and vice-versa. Those with power often try to obstruct changes which may deprive them of their status. This is true of individual human behaviour at any policy level and within any jurisdiction - the polity, the bureaucracy, hospital management or group practice. As organisational theorist Charles Handy points out:

"Organisations used to be perceived as gigantic pieces of engineering, with largely interchangeable human parts. We talked of their structures and their systems, of inputs and outputs, of control devices and of managing them, as if the whole was one large factory. Today, the language is not that of engineering but of politics, with talk of cultures and networks, of teams and coalitions, of influence of power rather than control, of leadership not management." (Handy 1988, p.89)
Reform at macro-level may involve redistribution of resources in national health care systems. Currently and historically, the curative sector of health care receives the largest share, leaving prevention and rehabilitation services wanting to alter the balance. Other reforms may involve change to the funding mechanism, such as the introduction of prospective payments systems (e.g. DRG/Casemix) to replace historical-base budgets, or change the remuneration system from fee-for-service to capitation or a mix thereof. At the macro-level, health departments are experimenting to implement new forms of health delivery based on purchaser-provider split, different forms of capitation payments, DRG/Casemix systems and forms of managed care. Bureaucrats are having to deal with the consequences of managing in the new quasi-market environment in health care. Reforms such as casemix funding and provider-purchaser separation have brought with them management challenges quite different to those facing managers in the past. At the meso-level, hospitals and their managements must change significantly to develop new skills and structures to address the issues and to ensure viability of their institutions. (Duckett 1994) Braithwaite records evidence of the change taking place already:

"Throughout the OECD, the hospital, that enduring and pervasive organisation which has delivered the vast majority of acute care services for decades, is being reconceptualised. ... [T]rends clearly indicate that the existing concept of the hospital is rapidly coming to an end. The emerging model consists of a core facility comprising only the most acute services, intensive care, operating theatres and an accident and emergency unit, with all other services and units linked by information technology to each other and to the core facility. ... We have referred to the new arrangement as the boundaryless hospital." (Braithwaite et al 1995b, p.87)

Hospitals, especially large teaching institutions, are hard to manage because of their complexity, including often conflicting objectives, the different types of tasks
required, advances in technology which enforces change, and external forces such as funding arrangements.

"Measuring, monitoring and improving the quality of care and organisational performance and coordinating the various functions and components of such organisations (as modern hospitals) is a task of monumental proportions." (Braithwaite et al 1995b, p.91)

3.3 Linkages between Primary, Secondary & Tertiary Care

The integration of the various levels of care is an apparently intractable management problem in health care systems. Two factors are important in this issue. Firstly, the continuity of care and the quality of that care for the patient, and secondly the financing ramifications which include cost-shifting. There are cost differentials between the different levels of care, and economical use of resources dictates that care should be provided at the level where the cost is least while quality remains high. The major problem in this area is the lack of linkage between the various levels of care, resulting in a lack of coordination which could organise the right fit of patient-need to the appropriate level of care. Linkage of levels implies a knowledge of resources available in a given area, and an organisational structure to permit coordination. Most health care systems lack this type of structure at present, and this issue has been identified as a problem area. In Australia, GPs have wanted more recognition from other areas, especially the hospital sector.

"There are many opinions about the form of this integration, and at present no suitable conceptual framework has been developed for assessing the various options. ....Information sharing and referral, networking, shared care, co-location of services, joint planning and more formalised levels of coordination were suggested, ....(but) if organisations do not see the benefit of working together with general practice or feel that their own survival is threatened, conflict and resistance are probable. There needs to be a very strong impetus for collaboration. This suggests that greater integration between GPs and the rest of the health sector may be hard to achieve, especially in light of the differences in organisational structures." (Australia. Commonwealth Department of Health & Family Services 1996, p.203)
4. Reforms to Health Care Systems

Changes within societies have caused health care systems to respond. The boundaries between health care needs and welfare needs of different groups within a society shift according to the medicalisation of social ills. (Hurowitz 1993; Mechanic 1993, 1995, 1996) The boundaries between the political and the administrative spheres of influence shift with new organisational and managerial techniques. (Starr & Immergut 1987; Vinten 1993) The degree of patient autonomy and clinical autonomy, and the effect of consumerism and the concept of 'patients' rights', alter the boundaries of the doctor-patient relationship. (Charles & De Maio 1993; Kassirer 1994; Polliit 1988; Potter 1988; Saltman 1994; Tailor & Mayberry 1995) Changes to the locus of power in intergovernmental relations shift the boundaries in federal/state responsibilities and hence of both funding of health care and provision of health care programs. (Butler 1991; Chapman 1984; Fletcher & Walsh 1992; Gerritsen 1990, 1992) The increase in complexity which causes such shifts is brought about by population changes, such as an aging society, epidemiological changes in mortality and morbidity and changes in technology which provide more and greater tools for clinicians to use. Management practices which have altered the focus from inputs to the system to outputs and then to outcomes (Duckett & Swerissen 1996; Terris 1988) have been responsible for increases in complexity, underscoring the need for bigger and better data and information systems. (Anand 1995; Bloomfield 1991; Boyce 1996; Britt & Miller 1993; Davenport et al 1996; Fleming 1991; Gold et al 1995/6; Gostin 1993; Henderson 1991; Hindle & Scuteri 1988; Krieger 1992; Miller & Britt 1993; Shiel
1993) At hospital organisational level, reforms have appeared to cast these organisations as 'instruments for the attainment of hierarchically defined goals' (Degeling & Anderson in Gardner 1992, p.51). The instrumental model of organisation when applied to hospitals tends to ignore or deny the significance of the conflicts engendered by management reforms. The source of rules within hospitals often stem from the different professional groups, whose expertise and values prescribe the standards and norms of good professional practice. (Weiner 1988) Such care-oriented rules often conflict with resource management rules inherent in management reforms,

"demonstrated in the now frequent debates and conflicts within health-care organisations about issues such as service rationalisation and productivity savings, and the effects of both of these on the quality and quantity of services being delivered." (Degeling & Anderson p.58/9)

The introduction of competition into such a strife-laden arena can only complicate an already complex situation. (Ford 1994; Harris 1977; Huppes & Van Bekkum 1989; Wiley 1994)

Most reform is evolutionary change, made up of incremental steps in policy-making to accommodate the shifting boundaries of relationships between system elements. Occasionally, however, a radical, perhaps revolutionary, change is made, such as the introduction of competition into previously publicly provided and planned services (UK, NZ, and some Australian states) or the introduction of regulatory planning into previously market-led environment of health care (USA). Ultimately, though, reform is a political process, and health care reforms are attempts to change boundaries where conflict breaks out. (Newbrander & Parker 1992; Parsons 1988; Salter 1995, 1994b; Thier 1991) The reforms to date have
focused on restructuring parts of systems, including health departments and hospitals, and implementing different types of management, such as clinical directorates where clinicians are formally and overtly responsible for budgets (and rationing). Some problems have not been addressed by the reforms. For example, the changes to date have done nothing to alleviate the problem that the lower socio-economic sections of society are the sickest and most in need of health care provision or insurance. Competition between providers can only exacerbate this problem, because it destroys the collegiate ethos. The objective for equity in the provision of health care cannot be served by competitive practices. Equity concerns fairness, so that often it is necessary to be unequal in resource allocations if equity is to prevail. In health care, as in the public provision of education, the goals of efficiency and effectiveness sometimes must give way to the goal of equity. The reform agenda now needs to focus on issues such as quality of care and appropriateness of care, (which will be difficult to maintain if efficiency is the first priority), and related issues such as consumer choice and the measurement of outcomes.

In order to judge the outcome of reforms, the following criteria are suggested as potential indicators of success. Firstly, the reforms must give the health care system added ability to improve the health status of the nation. But, as the health of the nation depends on many factors other than the provision of health care, a prerequisite is knowledge of efficacy of treatments, and a better understanding of how various factors as mentioned above affect health status. Secondly, health care resources should be shared equitably between all citizens. But equity can mean equality of access to health care, or equality of care or equality
of some other variable. It is possible that in this context, equity does not mean equality at all, but infers some sort of social justice in the allocation of funds, so that some groups receive a far greater share of resources than other groups. Thirdly, reforms must acknowledge all the stakeholders involved, which means those who pay (i.e. taxpayers in most cases), those who provide the services and those who receive the services. Changes in social policy will always produce different sets of winners and losers, and the reforms must constantly aim at balancing the interests of all. Fourthly there is the balance between the three major areas of health care policy - prevention, curative services and rehabilitative care - to be addressed. A major or minor theme running through health policy reform is the restoration of balance between these areas, because most resources are presently taken up by the curative medical services.

Judged by these criteria, the reforms of the health care systems in the five countries have failed. Not only have they neglected to even address the issues enumerated here, the reforms have caused administrative costs to rise and inequalities to multiply. Some of the reasons for the failure lie in the misplaced belief in the introduction of quasi-market strategies in Australia, NZ, UK and Canada. Other reasons stem from political pragmatism and outright political arrogance, as instanced by Dr Wooldridge's legislation in Australia to prohibit the issue of provider numbers to medical graduates. In the USA, the reasons for the spectacularly abject failure of the Clinton reforms are buried deep within the psyche of the American people. The history of their distrust of government, indeed the nature of the checks and balances of that governance which now no longer reflect the threats to that governance thus resulting in administrative gridlock, have played
their part in the failure. The lack of analysis of institutional power, the failure to build on the medical profession’s enthusiasm for reform, and the perceived secrecy of the reform committees all added to the outcome. Perhaps the greatest stumbling block was the power of the insurance industry and its lobbyists. Looking at the overall picture, it is fair to say that failure in the first four countries can generally be blamed on the misuse of economic theory; in the USA however, the problem of 40 million citizens without health cover is more of a moral problem, although the profit factor figures largely in the apportionment of blame for the health system being so costly and inequitable. More detailed reform strategies and their effects are discussed in Chapter 7.
Chapter 4. SOCIETAL BASES of HEALTH CARE POLICY

1. Introduction

This chapter deals with the issues in Box 1 of Diagram 1. (See p.43) These are the broad political and social factors, such as the history of the society and the dominant philosophy, attitudes and mores, which underpin the public policy process and the components of health care systems. Together with the economic system, these factors help to explain why countries have either chosen or evolved the elements of health care systems outlined in the previous chapter. Diagram 1 shows these broad factors as informing the Weltenschauung of a society, which underpins the public policy process. Whether the society has a dominant ethos of individuality, as in the USA, or a community collective, as in Canada, will help to determine if health care (and good health status) is seen primarily as an individual responsibility or a community responsibility. This underlying philosophy will be reflected in public policy, where the provision of health care is placed somewhere on a continuum which makes it either a public good or a market commodity. It is also a factor in how policy-makers view the requirement for and availability of health insurance, funding mechanisms, the reimbursement mechanisms for providers and the regulatory mechanisms for their training, the degree of central planning or reliance on market forces which will be politically acceptable, and a host of other issues and factors. The differences between Canada and the USA provide an example of this. According to Evans (1992a, 1992b), the Canadian system of universal public insurance for health care is by a considerable margin the nation's most successful and popular public program.
"Far more than just an administrative mechanism for paying medical bills, it is widely regarded as an important symbol of community, a concrete representation of mutual support and concern. In a nation subject to strong divisive forces rooted in both geography and history, the health insurance system is an important unifying idea as well as an institution. It expresses a fundamental equality of Canadian citizens in the face of disease and death, and a commitment that the rest of the community, through the public system, will help each individual with these problems as far as it can." (Evans 1992a, p.362)

David Peterson, the Premier of Ontario in 1989, has been quoted as saying of Canadian Medicare that "there is no social program that we can have that more defines Canadianism or that is more important to the people of our country." (Evans 1992a) This contrasts sharply with the situation in the USA where there is not the commitment of the community to provide health insurance to approximately 40 million citizens currently without health care cover. There is profound ambivalence in American society about whether medical care for all society is a social good, or whether it is a benefit which employers should purchase for their employees and dependents, with government insurance for those outside the work force. This ambivalence is the product of societal values and the role of the government in the financing and provision of health care. This role is one of the key differences between the health care systems of the USA and other developed nations. (Fuchs 1986; Iglehart 1991, p.255; Luft 1991, p.173 ) The health care scene in the USA has been described as 'a paradox of excess and deprivation' (Enthoven & Kronick 1989), with much of American medicine's success derived from an

"aggressive pursuit of innovative medical, surgical and drug treatments through increasingly complex and expensive research and development." (Mechanic 1993, p.12)
Per capita spending on health is 40% higher in the USA than in Canada, its nearest competitor, and at least 65% higher than any European country, but morbidity and mortality rates are worse in the USA than in any other OECD country. (Schieber et al 1991; OECD 1994a, p.317) Joycelyn Elders, MD, the US Surgeon-General designate in May 1993 argued that the problem is social and organisational. (Marwick 1993) In contrast to the USA, Australia's allocation of 8% GNP to Australian Medicare provides universal health insurance cover, and a comparative analysis of the quality of care provided and international morbidity and mortality rates shows that Australia's population (excluding Aboriginals) is one of the healthiest in the world (AIHW 1992, 1994). New Zealand is similarly placed, with Maori morbidity and mortality higher than the rest of the population. (Laugeson & Salmond 1994, p.13) NZ has the dubious distinction of introducing the most radical of all the health reforms, changing a once heavily regulated public system originally modelled on the UK's and particularly Scotland's, to one with substantial competitive elements. (OECD 1994a, p.29) NZ was one of the first countries in the world to develop a public hospital service as part of its welfare state, and the provision of 'free' public hospitals has been the major feature of its health system since 1938. (Boren & Maynard 1994, p.234). The other welfare state, the UK, provided, in its NHS, a model to emulate with its universal coverage, a sense of equity, global budgeting and minimal interference with the practice of medicine. Measured by any objective criteria and compared with vastly more expensive health care systems in the OECD, the NHS performed well and was cost effective. (UK Health Policy Network 1995, p.483) But inefficiencies and wasteful practices within the system led to changes which Klein (1995) has labelled as 'big bang health
care reform. Given the political, social and economic factors which underpin health care systems, all the reform attempts must be viewed from the 'big picture' perspective. The health care sector is an important industry in all OECD economies (see Table 6 below), but governments must endeavour to look beyond the immediate problems of public finance and deficits to the broader issues of efficiency of health care provision and the outcomes in terms of health status. As unemployment rises, it will become harder for governments to ignore the fact that much public policy is a causal factor of ill health in populations. While parts of government contribute to the cause, other parts of government struggle to contain the costs of amelioration of the problem. In the USA, it is becoming clear that profit is probably the major contributor to the problem of escalation of costs, falling quality of care, and loss of clinician and patient autonomy as more for-profit institutions enter the health care industry. (Braveman & Bennett 1995; Cassell 1996) Table 6 shows the size of the health care sector in terms of its share of employment in the 5 countries, and underlines the potential impact across the entire economy when structural reforms are implemented.

<table>
<thead>
<tr>
<th>Table 6. Employment in Health Care, 1970 to most recent year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per cent of total employment</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>United States</td>
</tr>
<tr>
<td>United Kingdom</td>
</tr>
<tr>
<td>Canada</td>
</tr>
<tr>
<td>Australia</td>
</tr>
<tr>
<td>New Zealand</td>
</tr>
</tbody>
</table>

Source: OECD 1994, p.63
2. Societal Factors

Bates & Lapsley (1985, pp166-7) list six major elements within a society which contribute to the structure of systems which provide for the health and welfare of that society. These include the geographic size of the country, the age and ethnic composition of its population and its distribution in that country. The political structure including the distribution of power and status in the society, the country's total economic resources and the philosophy by which the country's wealth is apportioned are potent factors. The level of sophistication of its scientific knowledge and available technology, as well as the history of the country including major social or natural upheavals it has undergone (such as earthquakes, wars and revolutions) are major elements. Lastly, the religions within the society and the values and ideologies underlying those religions will dictate the direction of elements of health care systems such as views on community rating versus cherry-picking in health insurance. Roemer (1985) has suggested 8 attributes of health care systems: their basic ideology and structure; the economic support including methods of funding and amounts; their health manpower policies and practices; the health facilities and their functioning; the pattern for delivery of ambulatory health services; the organised preventive services, environmental and personal; the regulatory strategies; and the mechanisms of administration and planning. In terms of the characteristics of political structures and social systems, Levine (1980 in Mayne 1993) suggested the following to explain differences in policy outcome: constitutional structure, (e.g. federalism); party structure; cabinet structure; structure of administration; and the civil service.
The systemic frameworks of policy, the scope of political activity, the configuration of issues and content of policy all depend on the institutions, participants, resources, the role of the state relative to individual responsibilities, and the capacity of the state to work its will. The constraints within the policy-making process, and the serendipitous moments that produce innovation as well as the tendency for policy to have unintended consequences, also have an effect. In the UK, the radical reforms imposed by the Thatcher government were designed to change the dynamics of Britain's health care system while preserving its structure and method of financing. (Klein 1995) The reforms were based on the theory of market place regulated competition (i.e. competition on the supply-side only) to identify inefficient hospitals, empower consumers and make medical practitioners and other providers more efficient. The structure of the Conservative Party, the Cabinet, the administration and civil service were instrumental in permitting such radical reforms to be imposed with all legitimate concerns stifled. Academics calling for pilot studies to be carried out first were rebuffed, with the Chancellor stating that such caution was unnecessary. Since the first 'explosion' of reform in 1989, however, the reforms progressed incrementally, almost is if the system were inventing itself as it progressed.

"Despite the five years since their inception, the reforms were introduced only gradually, through the clever ploy of calling for volunteer hospital trusts and general practice fundholders, thereby creating the proverbial bandwagon." (Harrison 1995, p.239)

The structure of NZ's government also permitted reforms to be imposed unilaterally. Academics' concerns were similarly dismissed. By contrast, academics
have played leading parts in Australia, with their design of Medibank, the forerunner of the current Medicare insurance scheme. (see Scotton & MacDonald 1993)

3 Structure of Governance

A significant factor in the complex interaction of social, economic, political and medical variables which make up health care policy is the structure of the government. The framework of government creates inter-relationships between the various levels - federal, state/provincial, local - which are important determinants in shaping and transforming social policy in general and health care in particular. The divisions of power amongst the various levels create incentives to shift responsibilities, and costs, and can thereby distort policy goals. Australia and Canada are federations with strong central national governments in partnership with strong state/provincial and territorial governments, enabling national health policy to be undertaken. In the USA the situation of a weak federal government and strong state governments creates difficulties in the formation of national health care policy except for defined groups of citizens such as the elderly, the very poor, war veterans and several other groups. The UK and NZ are both unitary states with strong national governments enabling national health policy-making, and with local regional governments to implement that policy. Local government has a more powerful voice in the UK than in NZ, and can provide checks and balances to the central government, as well as impeding or helping to implement central policies depending on the political colour of both governments. Australia, NZ, UK and Canada are all parliamentary governments, allowing the policy-making process to proceed without the impediments found in the system of separated powers in the USA. Governments in power under a parliamentary system may make and
implement health policies including far-reaching reforms to health care systems with comparative ease. If the population doesn't like the result, the government may well be voted out of office at the next election. In the USA, as President Clinton has discovered, the force of the 'iron triangle' of interest groups (Petersen 1993), congressional committees and bureaucracies can halt policies and reform proposals, even if the President and the two houses, Senate and Representatives, are of the same political party. This was the case between January 1992 and November 1994, when Democrats were in the ascendancy and President Clinton was trying to introduce reform to the American health care industry.

3.1 Federalism

Federalism and intergovernmental relations are important issues in health care policy, for, as Chapman (1988) notes, "intergovernmental organisations constitute a fourth branch of government and operate as moderating institutions in the federal policy process." Australia, Canada and USA may be compared in terms of federalism impacting on health policy. The interactions involved in the decision-making processes, and how these affect the actual delivery of services and particular programs in the health care policy field are of crucial importance. As Butler (1991, p.xi) notes, the federalist system of government in Australia, superimposed on the characteristics of the size of the health care industry and the fact that it is one of the 'big three' areas of social policy (with education and welfare),

"weave a complex web of administrative arrangements aimed at achieving oft-conflicting policy objectives - a wonderland for scholars of public policy!"

The implementation of the Special Premiers Conferences which began in 1990, and the Council of Australian Governments (COAG) which grew out of these meetings,
may address Butler's concerns to some extent. However, COAG's role has been defined as increasing cooperation amongst governments on the reform of the national economy and the ongoing structural reform of government. Its current objectives are to achieve microeconomic reform, with the emphasis on competition policy as per the Hilmer Report (Australia. National Competition Report, 1993). Whether COAG can help in terms of Australian health policy is open to doubt if competitive market principles are seen as being the answer to greater efficiency and effectiveness in the health care system. COAG's Report of April 1995 on reforming health and community services proposed the restructure of the organisation, funding and management of health care services in terms of "providing better outcomes by becoming more people focused". (Australian Community Health Association 1995, p.9)

3.2 Structure of Bureaucracy

Australia and Canada have departments or ministries of health, at both federal and state/province level with the health minister(s) responsible for health policy within their own levels of government. Australia therefore has 8 health care systems and Canada has 13. This allows a potential for both cost- and blame- shifting to occur between bureaucracies. UK and NZ have central government ministries of health, with other bureaucracy at the council or municipal government level. The smaller and weaker local governments do not have the same potential for forcing changes, as do the states/provinces in Australia and Canada, but as mentioned above, do provide certain checks and balances. The USA has a federal department of Health and Human Services, which is responsible for the few health programs of a national nature, i.e. Medicare for the over-65's, Medicaid for the indigent, Veteran's Affairs
for returned soldiers and their families, etc., and each state has a health department, which effectively administer the national programs. In terms of bureaucratic organisation, Canada and NZ have a large number of relatively small departments each responsible for a particular policy area, while Australia and USA have a small number of relatively large departments. In NZ, a plethora of ad hoc boards reported to the federal government until the administrative reforms of the late 1980s rationalised the situation.

4 Politics

The formulation of health policy will depend upon the degree of power and influence exercised by the many interested stakeholders. In Australia, Canada, NZ and UK, the national health care systems were generally viewed, prior to the 1990s, as somewhat beyond politics, in that they were government-funded, were accessible to all and the provision of health care was not dependent upon the ability to pay. Since the introduction of tenets of economic rationalism, however, politics has returned to the health care arena. The attempt at rationalising the number and placement of hospitals, for example, and their change in status from (often revered) public institutions to hospital trusts and corporate entities, politicised the health care system in UK and NZ. The introduction of DRG/Casemix-based funding in Victoria and South Australia politicised those health care systems. The attempted changes to Medicare by the Australian federal government - by bringing in patient co-payments, the non-issuance of Medicare provider numbers to graduating medical students, and the review of the numbers of foreign doctors permitted to practice in Australia - have brought politics back into health care in Australia. In the USA, on the other hand, the health care industry is a blend of free market, regulatory and
government-owned systems. Aspects of political territorialism, power and influence all play a dominant role, and the complex operation of these factors permeates the entire process on at least two levels: the political and the public. Politics is budget-driven and constituent-oriented, with lobbying by interest groups of providers, consumers and producers. Political Action Committees (PACs) contribute huge sums of money to campaigns for individual politicians. (Brightbill 1991) Of the 21 senators receiving more than $200,000 from medical industry PACs, 12 serve on the Senate Finance Committee, which makes decisions about Medicare and other health-related matters. The 25 House members who have received the greatest amounts of medical industry PAC money all hold leadership positions in the House or are members of the Ways and Means or Energy and Commerce Committees. (Navarro 1995, p.193) The American Medical Political Action Committee (AMPAC), the political arm of the American Medical Association (AMA), contributed $2.4 million to candidates for Congress during the 1989-1990 campaign and $2.9 million for the 1991-1992 campaign. (Sharfstein & Sharfstein 1994) Some industries give generously to both Republican and Democrat party members, and the main purpose of these medical industry contributions is to buy influence in Washington for physicians, hospitals and insurance and pharmaceutical interests. The political influence of the medical-industrial complex is enormous, and it has been shown that the behaviour of legislators is heavily influenced by donations. (Navarro 1995, pp.193, 195) There are many powerful religious organisations and citizen groups such as the American Association of Retired Persons (AARP). Within the medical industry there are power games as specialties compete with each other for funding. Professional associations for nurses, physicians, and other
providers compete with each other for their own agendas. An example of the power wielded by these groups is demonstrated by the American Medical Association's (AMA) and the American Hospital Association's (AHA) campaign against President Truman's national health plan in 1948. Despite Truman's efforts to allay public and congressional fears, the program of National Health Insurance was dismissed as 'socialist'. The AMA was and still is supported by a political and popular culture of individualism and autonomy within a free market. A further example of the medical lobby in the USA occurred in 1965 when Congress decided on an 'historic compromise' - the choice was between prioritising either 'fair access' for the poor, elderly and handicapped, or autonomy for consumers and providers. Congress decided to broaden government support in the area of entitlement spending while protecting professional discretion in areas of price-setting. Provider autonomy, especially that of specialists, was sustained, resulting in dramatic increase in hospital costs. (Blumenthal 1995; Navarro 1995; Mechanic 1993)

The Center for Public Integrity conducted a year-long investigation of the decision-making processes of the US government during its work on health care reform. The results suggest that health care reform has become the most heavily lobbied legislative initiative in recent US history. In 1993 and 1994 hundreds of special interests spent over $100 million to influence the outcome of this public policy issue. (USA.Center for Public Integrity 1995)

"Whatever one thinks about reform (of the health care system in the USA), it is useful to know that a single group, the National Federation of Independent Business, has successfully devoted two-thirds of its annual budget - about $40 million - to killing the 'employer mandate' by which the Clinton administration proposed to finance much of reform." (Editorial, Health Affairs 1994; 13(4): 6)
The political and social factors will determine whether a country provides a national health system, either as a service or by insurance, how much the market will be permitted to enter the system and the mode of funding for the system and remuneration for the providers. The following quote illustrates how the interplay of factors in Australia and the USA produce very different macro-level political/bureaucratic cultures:

“If Australians are sometimes horrified by the open horse-trading of American coalition building, those from the United States in turn often find our political system too closed, with policy decisions dominated by a relatively small and privileged band of politicians and bureaucrats.” (Davis et al 1993, p.6)

a) Macro Level - Legislative Policies

The issues in Box 2 of Diagram 1 are involved at this level. In terms of health care systems, the differences translate into a huge health care industry in the USA, a mixed system of national programs for certain segments of society, state programs for others, but the majority of people (60%) must rely on private provision. The paradox of the USA is that of all OECD countries, it spends the highest percentage of GNP on health care, yet has the worst outcome in terms of the highest morbidity and mortality statistics. This is a country with 1,500 insurance companies, where the amount available for spending on health care is open-ended because there is no total global health care budget allocated from the country’s GNP, and where approximately 25% of that spending goes on administration. (Woolhandler & Himmelstein 1986) In America, health care is seen as an individual responsibility, where welfare statism is not readily tolerated, and where the very best medical care, as a market commodity, is available to those with the ability to pay for it. Those who cannot pay must either go without, or accept public hospital care which is
limited in both quantity and quality. Two major federal health insurance schemes, Medicare and Medicaid, are available for the very poor and the aged. Individual States are beginning to institute reforms (see Barrand & Schroeder 1994; Cantor 1993; Lewin & Sybinsky 1993; Sparer 1993; Charatan 1992; Miles et al 1992; Moon & Holahan 1992; Editorial NEJM 1992 327(15), 1090-91; Kronick 1990), but it is a piecemeal effort, and the accessibility to adequate health care is denied between 37-40 million U.S. citizens, which is approximately 15% of the non-aged (i.e. under 65) population. In contrast, Australia offers a fairly equitable system which guarantees health care to anyone who needs it, although some people may have to wait longer than others, and some may have to travel large distances to get it. Not only is there access for all, the health care is largely free at point of delivery. Australia is able to offer this health care service because of global budgeting at the macro-level, and state-organised and administered hospital care at the meso-level. Direct comparisons between the five countries, however, are unreliable because of the disparity in population size, the case-mix and many other issues. It does show up, however, the effects of different policy-making mechanisms and institutions at the highest, or macro-level. National policy on the evaluation of new medical technology, its implementation and geographical placement is an example of cost containment practiced in Australia but not in the USA. Whether or not doctors' fees are capped in some manner is decided at macro-level. In most provinces in Canada, medical practitioners may charge what they wish for each service, but their annual income may be capped. Anything earned in excess of this figure is discounted by a percentage, thereby taking away the incentive to over-service. In Australia during the last 10 years the Medicare scale of fees has not kept pace with
the consumer price index, and the medical profession, mainly general practitioners, is subsidising Australia's health care system to a degree not formally acknowledged. This situation creates a perverse incentive for over-servicing, and may lead to a lessening in the quality of care. Other macro-level policies include health care insurance, both public and private (voluntary) and the type of rating allowable, i.e. community versus risk rating. Policies on costing, including cross-subsidies, true costs or average costs (for example diagnosis related groupings (DRGs)), pricing and rate setting will all be discussed at this level, with input from interest groups at this and other levels below.

b) Meso-Level - The Delivery Structure: Institutions

The issues at state/province/region level concern organisational structure such as regionalisation, rural provision, equity considerations and the medical and hospital components of the systems, and will address the ramifications of the public/private mix of institutions, etc. In terms of funding, the issues concern the allocation of resources within state/area and remuneration to providers. State/province politics play a large part in policy-making at this level, and will involve the choice of decision-making models such as formulae for numbers of beds and other elements, networking between institutions and perhaps the programs of care to be provided. Evaluation of policy outcome is important at this level. In terms of the structural model (Diagram 1), meso-level issues are found in Boxes 1 and 3. Components and factors at this level will determine policies on the delivery structure of the system, the allocation of budgets to provider organisations, the education of health care personnel, and micro-level funding. There will also be links to factors in the macro-level as well, for decisions as to the mix of public, private, for-profit, not-
for-profit hospitals and institutions will depend to a large extent on the planned versus market-oriented philosophies of policy-makers. The structure of the hospital system will include whether or not the number of hospital beds is decided by government or entrepreneurs, whether there is any regulation in geographical distribution of health care institutions, and the types of management permitted or obligatory. This is usually tied in with other macro-level policies such as type and range of health insurance available, and whether it is voluntary or mandatory.

The structure of the personal (ambulatory) health care system, which provides medical care (primary care, general practice, family medicine), as opposed to hospital care, will depend upon policies for the mix of private versus state-employed practitioners, the ratios of general practitioners to specialists, and the various factors affecting practitioners such as education and training, manpower planning, geographical distribution, their perceived role(s) and the interface between primary and secondary care. One of the major differences between the USA and the other four countries is the ratio between general practitioners (or family medicine practitioners) and specialists. In the USA, only approximately 15% of providers act as general practitioners (GPs), and there is no 'gatekeeper' role which separates out the mundane and the general from the more serious cases which require the services of specialists. Iglehart (1994e) has estimated that by 2000, there will be a surplus of 165,000 specialists in the USA because of the pressures growing under managed care to reduce the amount of in-patient care and the number of interventions. With the advent of managed care, many of the features of primary care as it is known in Australia and the UK are surfacing in the USA as strategies. (Iglehart 1992d, 1993b, 1994a) In Australia and Canada, over 50% of medical
practitioners are GPs. As specialists' fees are greater than GPs' fees, there are ramifications in the overall costs to the various systems stemming from policies which regulate the professional bodies and the education and training of medical practitioners.

Other policies at the meso-level concern the structure of the public health system, including funding, the health care programs themselves, their intended coverage and organisation. Some public health services are delegated from state level to local government level, such as in Australia, and also the UK and NZ, in which latter two countries there is no state-level in the unitary system of government. Policies concern such issues as child immunisation, food handling, sanitation, and environmental issues such as work-place safety.

c) Micro-Level. The Delivery Structure: Clinical & Managerial
At this level, issues concerning:

- the role of the provider, such as their beliefs and value systems, remuneration of providers and interest group pressures;
- the organisation and management of hospitals, including their sub-groupings and cultures;
- local politics;
- community input - needs assessments, etc;
- evaluation of health care interventions & treatments, including the use of randomised clinical trials (RCTs), and outcomes research will be taken up by the policy-making process.

The components and factors at this level (see Box 4 Diagram 1) determine the costs of the system to the patients, and where the private sector is concerned, the returns to the practitioners and insurance companies. Input from the stakeholders and interest groups help (or hinder) the policy-making efforts at the meso- and macro-levels, and include the issues outlined above as well as remuneration methods which include fee for service, salary, capitation or contract, or a mixture of these types.
Interest groups include medical and allied health care practitioners and their Colleges, Associations, etc.; consumers (patients) and their advocates; insurance companies (& employers); administrators of facilities (hospitals, etc.); and politicians/legislators and bureaucrats. Issues affecting the quality of services provided include the equity-efficiency tradeoff, and the measurement of outcomes, such as clinical trials and other research which will give information on the effectiveness of treatments and interventions. It is at the micro-level that the issues of medical autonomy, the increasing surveillance of professionals by management and the increasing accountability of those professionals are being debated.

4.1 Factors Linking all Levels

Factors associated with system structure and process, and stakeholder behaviour are the links between macro- meso- and micro- levels of policy-making. Structural factors include the role of institutions and the role of the state; the economic system with its underlying assumptions; the lobby and interest group power; and intergovernmental arrangements. Behavioural factors include the beliefs and value systems of stakeholders who may be anyone in the health care system or policy-making arena including policy analysts and economists. Also of importance is the locus of power. Factors concerning process include methods for obtaining community health requirements; information gathering generally, and dissemination and analysis of data. The trend towards evidence-based medicine requires the use of health records and large databases, for example meta analysis of random controlled trials (RCTs). Evaluation factors include both method and practical operations for surveying and measuring policy and program outcome, for example the use of statistical methods in outcomes research.
5 Health Insurance: Public and Voluntary

One of the most distinctive (and potentially divisive) aspects of any country's health care system is the set of arrangements in operation that reduce or eliminate the financial burden of illness experienced by individuals. (Palmer & Short 1994, p.58) Most health insurance schemes incorporate systematic cross-subsidisation of the sicker and poorer (and usually older) members of a society by the healthier, financially more able (and usually younger) members. Health insurance as an economic mechanism, either voluntary and paid by individuals, families or groups, or publicly funded by tax revenues and levies, will differ widely in its structure, process and outcome from country to country. In the five countries under review, the UK is at one end of the spectrum, with the NHS providing nearly all health services directly to the whole population free of charge, although approximately 13% now have private health insurance. At the other end of the continuum is the USA, where most medical and hospital services are provided by private enterprise, with the government restricting its role to the supply of services to specific groups, such as the aged, the poor, war veterans and other 'deserving' categories. Publicly-provided health care amounts to 40% of the total health expenditure in the USA. The other three countries generally provide some form of public health insurance for their entire populations. In Canada 28% of the population has private health insurance in addition to the national Medicare provision; in Australia the percentage has fallen from the 1976 figure of 67% to under 40% in 1996. In those countries where private health insurance or a mix of private and public insurance covers most health care services, the cost is the annual subscription, regardless of claims made.
There is no incentive for either physician or patient to think about the equitable allocation of resources in the use of health care services.

5.1 Health Insurance as a Political Issue

Palmer & Short (1994 p.59) encapsulate the issue of health care insurance:

"In most countries, health insurance and the closely related questions of how health services are to be financed and how doctors are to be paid have been contentious political issues at the times of major policy changes. The reasons for the conflicts associated with these changes are undoubtedly a consequence of the redistributive potential of policies in this area, and of the special role of the medical profession both in the health care system and in the wider social and political arenas. .... [R]edistributive policies are the most difficult to implement because of the opposition they generate from potential losers. When those losers include doctors, an affluent and well-organised group, who are able to generate disproportionately large political demands, it is hardly surprising that many issues associated with health care financing produce political conflict."

As Palmer & Short point out, however, it is only in the USA and Australia that (public) health insurance has been the focus of a great deal of political activity for at least the last 45 years. Health insurance per se has not been a political theme in the UK, New Zealand or Canada for some time, although there is argument in both UK and Canada about the level of private financing required in their respective systems. Scotton & Macdonald (1993 p.4) also make the point that Australia and the USA are the outstanding examples of countries where it has not been possible to reach a set of arrangements in which the health care providers are broadly reconciled to a negotiated role within a national health insurance program which has public support. These authors offer a possible explanation for the medical profession's continuing hostility to national health insurance and the extreme polarisation of their health politics in Australia and USA is the extent to which they had succeeded in entrenching their preferred organisational model, based on the autonomy of the professional. This may well stem from the fact that members of the medical
profession in Australia were very close to the British system, having in the earlier years trained in the UK and having experienced at first hand the NHS and how the administration of that system affected professionals' autonomy. In the United States, 'nationalised' professionals was anathema on both grounds of professional autonomy and that of individual rights and free market ideals.

Other political aspects of health insurance include the cost-pooling arrangements of many kinds which incorporate elements other than 'pure' insurance to cater for the interpersonal differences in health care utilisation and costs. Much of this variance is due to factors such as age, gender and health status, factors which are entirely predictable. As Scotton & Macdonald (1993, p.3) point out,

"[I]f the high-risk groups (the aged, the chronically ill) were richer than the low-risk groups, this might be of limited social concern, but, if anything, the reverse is the case. Hence, in the interests of equity, all the health financing systems of developed countries incorporate, in addition to protection against random losses, systematic cross-subsidisation of people in bad-risk groups by those in good risk groups."

Cross-subsidisation between risk groups can be accomplished in private health insurance systems by community rating, under which everyone pays the same premium, regardless of risk, or by the use of group rather than individual contracts, in which the groups may be rated according to risk. In the latter case, the cross-subsidisation takes place between members within each group. The former strategy is used in Australia, the latter in the USA. In both countries, however, the growth of health care costs has increased the transfer burden to the extent where voluntary cross-subsidisation is not enough. In Australia, the result is fewer people buying health insurance and relying instead on the public insurance system for provision of health care. In the USA, private insurers 'cherry-pick' or 'cream-skim' consumers
by offering lower premiums to the good-risk groups, leaving the bad-risk groups uninsured, which in America means without access to health care unless paid for by the consumer or by reliance on one of the few public institutions. Because of this growth in costs, governments have had to provide a greater share of personal health care expenditures, as well as regulating more and more the field of private insurance. Strategies include tax rebates to encourage people to buy private insurance which supports good-risk group members to pay community-rated premiums, and government coverage of poor and high-risk groups by providing public insurance. The USA enacted Medicare and Medicaid legislation in 1965 to meet the needs of the aged and the poor respectively.

Another political component is the fact that health insurance is a big industry. Any changes made to private health insurance have repercussions, especially so in the USA where there are approximately 1500 health insurance companies which together form an extensive payroll. If the USA were to put in place the reforms required to overcome their problem of having 37-40 million uninsured citizens, the numbers of insurance companies would have to be rationalised, causing huge upheaval in the American business scene; a scenario not likely to be enacted. As Enthoven has remarked:

"the US political system is incapable of forcing change in such powerful constituencies as the insurance industry, the hospital industry, organised medicine, the medical services industry and the pharmaceutical industry." (Quoted in Navarro 1995, p.195)

As well as having a disproportionately large cost component, health insurance affects the market in health services by freeing consumers from financial barriers, reducing constraints imposed from the demand side. Patients and physicians have no
incentive to select treatments and services on cost-benefit or cost-utility basis if insurance ensures payment. Governments react to demand-driven and provider-influence cost pressures by either cutting the benefits of insurance, or by the use of market power and regulation to try to constrain price and output decisions.

Scotton & Macdonald (1993, p.3,4) comment:

“The objective of equitable access to health care severely limits the extent to which scaling back benefit coverage is feasible or desirable, so that the practical outcome of widespread health insurance is that, having transformed the demand side of the health care market, insurers must sooner or later intervene on the supply side. The higher the level of coverage sought, the more thoroughgoing will be the level of intervention required. ...It is because of the contradiction between high levels of insurance and autonomy of providers with respect to prices and output that health insurance becomes a battleground between the suppliers of services - notably the medical profession and private hospitals - and governments, in their roles as subsidisers and direct insurers. Governments have more market power than private insurers, and more access to regulatory and legislative processes. They are also likely to be more strongly motivated to contain costs, especially as compared to private insurance organisations in which the service providers have a substantial or controlling voice. The larger the government share in funding and the more directly it is involved in the management of health insurance, the greater will be both its incentive and its power to intervene on the supply side.”

"The history of health care financing can be summarised by the statement that every developed country has reached the stage at which the replacement of a subsidised and regulated private system by a wholly or almost wholly public system has either been completed or become a major public issue. The evidence from international comparisons supports the argument that universal public programs offer the best framework for the simultaneous pursuit of the objectives of access, equity and cost control. These programs necessarily involve public intervention on the supply side, exercised through legislative and countervailing market power, which affects the level and composition of output, prices and incomes in the health care sector. In doing so they set limits on the economic opportunities, collective power and individual autonomy of health service providers and reinforce a basic conflict of interest between them and their governments."
6. Accountability

The concept of accountability runs through the issues in the political and social bases of health care systems and needs to be seriously considered to counter the vicissitudes of uncertainty, controversy and conflict inherent in health care policy making. Emanuel & Emanuel (1996) have described the different models of accountability at the different policy levels:

1. Macro-Level: The Political Model

At this level, it is the government which must be accountable to taxpayers/citizens to

i) provide policies leading to good health opportunities;
ii) to ensure adequate resources for health care provision, allocated across the different fields of health care, as determined by needs analysis according to social justice values, which are determined by the public;
iii) to ensure adequate planning and regulation for education and training of manpower, provision of facilities and materials for the present time and into the future;
iv) to satisfy provision of care, and basic scientific and medical research; and
v) to provide adequate regulation to ensure appropriate self-regulation in all professional spheres (Licensing Boards, dissemination of technology, etc.)
vi) To ensure that the profit motive does not destroy professionals' motivation to provide quality care, and to regulate so that remuneration systems provide incentive for quality and efficiency.

2. Meso-Level: The Economic Model

At this level, institutional management must be accountable to

i) patients for the quality of care delivered, and
ii) to purchasers and providers to ensure economic efficiencies, taking into account professional autonomy and quality of service;
iii) to government for just distribution of health care resources, to comply with audit requirements, and to counter the ill-effects of competition within an internal health market.

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3. Micro-Level: The Professional Model

At this level, clinicians and other allied health carers must be accountable to

i) their colleagues and associations as self-regulated professionals, and

ii) to their patients in the principal/agent doctor-patient relationship.

Clinicians especially must be more accountable for the assessment and evaluation of treatments, which means the participation in RCTs, collection of data on the efficacy of procedures, participation in Patient Outcome Research Teams (PORTS) and the support of evidence-based medicine. These processes must be endorsed by professionals and carried out in teaching hospitals and suitable clinics, whether for-profit or not-for-profit. (A leading example of such research is carried out by the Kaiser Permanente, a US not-for-profit health maintenance organisation.)

The pressure for accountability has led to a search for outcome measures. Carr-Hill (1994, p.1200) has specific warnings about the implications of the outcomes movement for equity and justice.

"It should be noted that philosophers have been worrying about consequentialism for a very long time as, in practice, utilitarianism has worked out rather nastily for the poorer and vulnerable. Rawl's Theory of Justice is a sustained attack on consequential theories which he objects to because they ignore claims of justice ... The emphasis on outcomes can disguise the injustice/moral wrongness of the act producing the outcomes. It is always possible to ask of an outcome, whether the activity which led to it is just/moral independent of outcome. Moreover, in distributional terms, the enthusiasm about outcomes can disguise, and even perpetuate, unfairness in the status quo. The concern with what will happen as a consequence of an activity, implicitly implies an acceptance of the (im)morality of what is actually happening. There will be cases in which a policy dictated by outcome measurement is one which is unfair or inequitable, or morally disagreeable. To advocate that policy is therefore to comply with the unfairness: hence the activity of measurement is morally suspect - or defeasible as Hart would have said."
7. Conclusion

The political and social issues inherent in health care policy-making, as typified by the concept of health insurance, bring into focus the need to consider social justice in the pursuit of health policies. Health care system reforms which concentrate on cost-cutting and deficit reductions rarely take into account issues of justice such as equity of access and outcome, and indeed, often compound problems such as the quality of care in the context of the pursuit of technical efficiency. The reforms in all the health care systems under review have made the market-place the *de facto* arbiter of who gets what. The effectiveness of voluntary health insurance has been diminished in Australia as policies have imposed financial disincentives on those who could afford to purchase premia. Such policies have directly caused great stress to be placed on the public health systems. At all three levels, the participants in health care policy making and health care systems operations must be accountable to their constituencies. There is some evidence to show that accountability issues are being addressed at meso and micro levels, but at the macro level, governments do not appear to accept their responsibilities and the strategies put in place to lower the health care budgets have exacerbated the problems. Governments have not ensured adequate resources, allocated across the different fields of health care, and policies other than in the health area are certainly not leading to good health opportunities. Very few governments have conducted needs analyses or public surveys to establish current ideas of social justice values in the community. The political and economic bases are effectively thwarting the reforms of health care systems by preventing the necessary agenda(s) emerging.
Chapter 5. HEALTH POLICY in the CONTEXT of SOCIAL JUSTICE

"There is no way to adjudicate disputes between the Holy Trinity of cost, quality and access unless a court of values is available to dispense its wisdom."
Quoted in Priester (1992, p.84)

1. Introduction

The question which needs to be posed to policy makers is whether or not they intend setting up a court of values, as advised by Priester above. If not, they must make clear the criteria by which they are judging who shall get what, when and how. The answer must be informed by ethical considerations of society's requirements. (Australia. NH&MRC 1990; Brody 1994; Charlesworth & Gifford 1992; Daniels 1994b; Dougherty 1992; Editorial Journal of Public Health Policy 1990) Patients of health care services should not face discrimination on factors such as ethnicity, socioeconomic status, age or gender. But the costs of such provision must be taken into account - health care resources are finite. Arguments therefore continue on who gets what and why, and in order to serve social justice, it is sometimes necessary to be unequal in the distribution of resources. Most people would recognise an unfair or inequitable situation at a basic level. But health care provision ranges from the basic to the extremely complex, especially when private health care provision is added to the picture resulting in public and private health care systems. This raises such questions as to whether well-off people ought to be able to purchase the health care they want (and not necessarily need in medical terms), while the rest of the population has to make do with publicly-provided care, which is often by inference, but not necessarily true, to be of inferior quality. Is it ethical to spend thousands of (public) health care dollars on
someone with only four months to live, while other patients are denied 'basic' treatment, or those with a chronic illness cannot receive subsidised help? Ought we spend resources on such items as IVF programs when basic services such as hip-replacements (which offer many years of better-quality life) are in short supply? The answers to such questions rely on value judgments, and this raises the question of whose values are taken into account and who makes the decisions. Various theories of social justice inform a society's choice of the way in which provision of public goods like health care is funded and organised.

2. Theories of Social Justice

There are many theories of social justice and each one will have its own concept of 'equality', itself an ambiguous concept, being invoked as either a substantive or an absolute principle, or as a second-order, procedural principle. (Goodwin 1992, p.358). In health care policy, the concept of social justice may be analysed at both these levels. As a substantive principle, social justice would be seen at the macro-level, where people in a given society may be seen as automatically deserving of publicly provided health care, irrespective of their race, nationality, age, social status, economic status or any other criterion. This is the case in Australia and the United Kingdom, and to a lesser extent in Canada and New Zealand. In the USA, health care is not a 'good' to be shared under the rubric of social justice. Here, the concept of 'just deserts' underpins the idea of social justice. Deserving of publicly provided health care in the USA are people over 65 years of age, people in receipt of income under an arbitrary income level, war veterans, and some other groups which conform to agreed criteria. Everyone
else has to pay for their own health care, or get a third party to pay for them, in the
form of insurance or direct payment. Thus in the USA, social justice is invoked at the
macro-level as a second-order, procedural principle, distributing health care as a public
good, in terms of impartiality, according to appropriate criteria, and by due process.
Different theories of justice identify different relevant criteria on which to base
allocation decisions, that is, which justify who gets what and why. The main
alternatives are those which justify distribution according to merit or desert, utilitarian
theories and needs-based theories. (Ramsay 1995)

2.1 Theories of 'Just Deserts'

These theories take a number of forms, each of which may make assumptions about
the qualities or characteristics of people. They may involve making judgments about the
moral or social worth of an individual - personal virtues, talents, skills, whether or not
the individual performs a socially worthwhile role or makes a significant contribution to
society - and the meritorious are deserving of reward. Or there may be sensitivity to
what a person has done in the past, and treatments will be given to those who have
acted responsibly as regards their health; resources will not be distributed to those
whose behaviour has contributed to ill health. This potentially penalises and justifies
discriminating against people who put a strain on medical resources because they
smoke, drink, overeat, take drugs or indulge in potentially lethal sports or risky
pastimes or sports such as rock climbing, bungy-jumping, speedcar driving, boxing and
the like. This 'just deserts' thesis underlies the allocation of resources in the USA,
where there is a clear differentiation between the welfare-deserving and the
undeserving. In the UK, Williams (1992) found, in a convenience sample of 80 people, that 40% thought that there should be no discrimination whatever between different sorts of people when determining resource priorities. Of the remaining 60%, the biggest group preferred a basis of discrimination according to whether people had or had not cared for their own health. (This latter attitude was particularly prominent amongst doctors and health service managers) In an interview survey based on a random sample of people aged over 16 in UK taken by the Office of Population Censuses & Surveys (n=2005), Bowling (1996) found that the public give priority to the young over the old, and there is some public support for discriminating against people with self-inflicted illnesses. The 'just deserts' approach is fraught with moral, theoretical and practical problems. There is no necessary or a priori connection between moral virtue, social worth and the amount of resources anyone should be given. Individual conduct and aptitudes are the results of hereditary and environmental factors, and ill health, states of disease and disablement may have nothing to do with an individual's free choice and living conditions. Using social and moral worth is morally objectionable, and will sanction further inequalities by doubly punishing people who are likely to already belong to underprivileged groups.

2.2 Utilitarian Theories

The basis of utilitarian theory suggests that what is morally right is whatever leads to the greatest good for the greatest number. Utilitarians aim to assess the total good, and each person's interests are given equal weight in the overall assessment. There are two versions of this argument:
Argument A.

Choices between people and treatments should be according to which choice leads to the greatest number of lives saved - therefore give resources to those with a greater chance of success in terms of lives saved. Practical application of this theory would lead to the allocation of hospital-based curative medicine, while leaving the chronically ill, the handicapped, the mentally ill and the dying under-resourced because results will not be so tangible.

Argument B.

Generally speaking, health economists claim it would be unethical to allocate resources to ends other than those which will produce the best effect. 'Best effect' is defined not in terms of lives saved, but on some other cost-benefit or cost-effectiveness formula. Rationing is based on providing service or treatment to the patient who benefits most per unit cost. The Oregon experiment (see below) and the use of QALYs are examples of this approach.

"Those who are involved in decision-making are not necessarily informed about all the issues and not all are representative of all the needs and interests of the population. 'Local Voices' are notoriously those of the articulate and assertive middle class and so reflect their values, beliefs and prejudices. Rather than embodying democratic participation, public consultation can lead to the common good being overridden by a set of particular interests." (Ramsay 1995, p.173)

Another instrument used by the utilitarian approach is cost-utility analysis, using techniques such as QALYs, which have been hailed by some as the solution to resource allocation problems. They are used as the criteria for beneficial health care, as a measure of efficiency and as a method of setting priorities. As Ramsay explains:

"QALYS are a technical instrument for assessing the total good, not by calculating the number of lives saved, but the number of life years gained (life
expectancy) combined with the quality of life during those years. Beneficial health care is one that generates a positive amount of QALYs. Efficient health care is one where cost-per-QALY is low. Funds are allocated to wherever they can generate the most QALYs. Particular criticisms of QALY calculations arise from the fact that in seeking to maximise 'life units', insufficient attention is given to whose they are. This can lead to systematic unfairness to particular individuals and groups. For instance, QALYs tend to favour the young over the old. If treatment is given to those who will as a result have longer life expectancy, then almost always younger patients will benefit. Similarly, life-enhancing treatments for the young will produce more QALYs than life-saving treatments of the old, or care for the chronically sick and terminally ill. Nor is it just the old or chronically sick who are discriminated against. When choice has to be made between two candidates with the same condition who are in other respects equal, if one has an additional set of circumstances (medical or social) which detracts from his prospective quality of life, then the one who is already the most fortunate should be chosen on this method. This makes pre-existing natural and social inequalities a relevant reason for further entrenching that inequality. Furthermore, because efficient health care is where cost-per-QALY is low, those conditions which are the cheapest to treat will take priority. The effect of this is seriously to disadvantage groups of patients with particular diseases or conditions for no better reason than the expense of treating them. Whatever aggregate benefit this produces, it violates individual's moral claims to equal consideration because preserving or improving the quality of their lives simply is not worth it."

2.3 ‘Medical Need’ as a Distribution Criterion

For many, the rational criterion for the distribution of scarce health care resources is obviously medical or clinical need. No moral judgment is needed about a person's social or moral worth, aggregate benefit or how much it costs to keep someone alive. However, there is a difficulty in defining needs and justifying their importance. Fair and just allocation is according to relative degrees of impairment in health or in ‘normal species functioning’, which is an important component of the ‘opportunity range’ open to individuals in a society. (Daniels 1982, p.72) The degree to which a person needs something is the degree to which the lack of it compromises a person's ability to function as a human being. This still leaves the problem of being able to identify and assess needs in practice. If experts assess and prioritise real needs, this might satisfy a
provision which ignores what people actually want, and might threaten individual autonomy and freedom of choice. To avoid this, public consultation and participation have become fashionable in needs assessment programs. As mentioned above, this produces the problem that people might get what they want but not what they need. People may not feel the need for or want what they (medically) need, because of their ignorance, inadequate health knowledge, material and non-material resources and because of their attitudes and beliefs.

2.4 Other Criteria for Allocation of Resources

Other viewpoints consider the 'first come, first served' criterion for allocation of health care, and strategies employing a lottery or random selection. These views don't involve discrimination on the basis of moral or social worth, overall benefit or degree of need, and each incorporates justice in the form of equality, equal access and equal opportunity. But when people are denied health care by chance, a 'scapegoat ethic' replaces moral responsibility for decisions, and justice becomes a contingent concept.

The ethical problems involved in the distribution of health care resources highlight the need for a framework which takes into account different values and the trade-offs between them, and which requires that criteria used must be made explicit, subject to public debate and democratic control. Such a framework would take into account the more fundamental issues of the potential under-funding of health services, for, however large the health budget, ethical choices in resource allocation will have to be made, and the question of whether the initial distribution - the resources allocated to
health - is itself just. (Ramsay 1995, p.174) The next section investigates the values inherent in an ethical framework for health care resource allocation.

3. The Place of Ethics in Health Care Reform

"Ethics... is merely the little province of that motley, growing tribe of bioethicists who hang around hospitals and serve on ethics committees - a useful group when their plug-pulling decisions help to keep costs down, but a nuisance in many other contexts." (Quoted in Huefner & Battin, 1992, p.x)

Health care reforms are, in the main, politically motivated with the debate involving policy-makers and health economists on the one hand and negotiations among interest groups and stakeholders on the other. If social justice is to be served, the health care reform debate cannot be confined to arguments of politics and economics, but must include the fundamental moral issue of how we treat people, especially people who are least able to defend themselves. As Dr K. Calman (1994), Chief Medical Officer of the UK Department of Health, puts it: there is a responsibility for us all to care (about how society will come to the aid of the ill and injured), and this is central to any value base.

3.1 Evidence of Ethical Argument

There has been little evidence to show that ethics per se has been given any meaningful part in the negotiations for change in health care systems, and there is mounting concern that reforms in Australia, New Zealand, Canada and the UK are in fact disregarding ethical values. Whitehead (in Robinson & Le Grand 1993) finds it extraordinary that, whilst the NHS was founded on equity principles, there has been so little official attention paid to the monitoring and ensuring the protection of those principles in the 'mammoth upheavals' of the 1990s. Of particular concern are the ethical dilemmas which will be thrown up by the greater financial incentives and market
pressures in the new system in the selection of patients and differential services. Managers and professionals in provider settings must discuss the ethics and practicalities of providing equitable services. In situations in the UK where area management teams are doing this, there is still no guidance for difficult ethical dilemmas, as the following example shows. The East Kent Health Authority had such a discussion on its agenda at its meeting held in May 1997. Budgetary cuts had forced the team to consider which areas would have reduced spending, and the case of surgical treatment for gender dysplasia was seen by the lay members as a convenient service to deny funding. The reasoning was that it was a costly procedure (80,000 pounds sterling), and psychiatric service was available to such patients. To their credit, the medical members of the committee (GPs) argued for further examination of the issue, saying in effect that the committee should “never say never” to any clinical treatment, but review each case on its merit. The ‘solution’ by this committee was to refer the question back to the smaller committee doing the in-depth analysis. In Australia, the NH&MRC has working parties for ethics and resource allocation, but the findings do not necessarily inform the policy process. While Australia provides a far more equitable health care system than does the USA, and a better system in terms of quality than the NHS, there are still many areas in need of attention, and which may be further emasculated by the competition-based reforms. The one exception (to lack of ethics argument) has been President Clinton’s efforts in the USA. He convened an ethics advisory group (one of 35 working groups) to advise on his 1992 health care reforms proposal. The Ethics Working Group of the Clinton White House Health Care
Task Force assembled in March 1993, and produced a list of ‘Principles and Values’ which the White House Domestic Policy Council published as *Ethical Foundations of Health Care Reform*. Included were such issues as:

*universal access to equal, comprehensive benefits that meet our needs over the life span;

*a fair financing system that imposes burdens according to ability to pay and distributes burdens fairly across generations;

*the wise allocation of resources within health care and between health care and other goods;

*the delivery of effective services and the avoidance of ineffective ones through the provision of high quality care;

*a simply organised, efficiently managed system in which individual choice, personal responsibility and professional integrity are all respected;

*fair procedures for making decisions and resolving disputes.

President Clinton was ready to frame the health care reform debate in terms of the moral values at stake, knowing full well that compromises would have to be made, and hoping that, with the input of ethical debate, the compromises would be based on acknowledged principles. Another reason for framing the debate in terms of moral values was to engage the public in the debate. The moral values at stake - universal access, fairness of burdens, quality and efficiency of care-, being readily understood by most people, who could give their opinions on the trade-offs required. Unfortunately for President Clinton, the power of vested business interests took precedence over moral values. (See, for example, Brightbill 1991; Achenbaum 1994; Easton 1994;
Rosenthal 1994; Martin 1995; Rockman 1995; Skocpol 1995b; USA Center for Public Integrity 1995)

3.2 Values

Dougherty (1992), an American medical ethicist, differentiates ethical values into intrinsic values and instrumental values. The intrinsic values are 1) respect for the dignity of persons; 2) caring in therapeutic relationships; and 3) protection of the least well-off. The instrumental values are: 1) service to the common good; 2) containment of health care costs; and 3) simplicity in the system of health care provision. Priester (1992), summarising the ‘New Ethic’ research project of the Center for Biomedical Ethics (University of Minnesota), also wants to place an explicit values framework at the forefront of reform to enable the public to hold policy-makers accountable, and to ensure that policies promote and do not detract from underlying values. Explicitly stating the values underlying the current system in the USA and comparing them with Canada, UK, Australia and New Zealand helps to explain why the USA is the only Western nation without universal access to care.

"Americans have placed individual concerns over the collective good - the converse of values embodied in the social policies of Canada and the European nations with which the United States is frequently compared." (Priester 1992, p.84)

Priester names six influential values - professional autonomy, patient autonomy, consumer sovereignty, patient advocacy, high quality care and access to care - as having been honed by the other values which form part of the ethos of the American way of life. These other values include: a strong faith in individualism, distrust of government and preference for private solutions to social problems, belief in American
some of these values are mutually exclusive, but were thought to be reasonable, achievable goals, although only physician autonomy was ever really fully realised. In order for ethics to be placed before economics, Priester suggests a new framework (see Table 7), which, while retaining all six values specified above, reorders and redefines some of them, re-emphasises several that have been neglected and adds some new ones, by which to guide the restructuring and reform of the US health care system. Priester notes that ordering rules for the values are as follows:

1. Each essential value should be maximised to the degree possible without threatening any other essential value, but fair access should be pre-eminent.

2. Essential values should be achieved before instrumental values, except insofar as instrumental values are a means to achieve essential values.

<table>
<thead>
<tr>
<th>Essential Values</th>
<th>Instrumental Values</th>
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<tbody>
<tr>
<td>Fair Access</td>
<td>Personal Responsibility</td>
</tr>
<tr>
<td>Quality</td>
<td>Social Solidarity</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Social Advocacy</td>
</tr>
<tr>
<td>Respect for Patients</td>
<td>Provider Autonomy</td>
</tr>
<tr>
<td>Patient Advocacy</td>
<td>Personal Security</td>
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Table 7
Proposed Values Framework for the U.S. Health Care System


3.3 An Ethical Framework

A feasible ethical framework acknowledges that trade-offs between the different values will be necessary, but having such a framework will ensure that the problems inherent in working out these trade-offs are brought out into the open and will be taken into
account. Philosophers Dan Brock and Norman Daniels, both of whom were involved in President Clinton's Ethics Working Group for the US health care reforms, found wide-spread consensus on the central role of the values and principles underlying the provision of health care. They discuss (Brock & Daniels 1994) the principles and values involved in the design of reforms to the US health care industry, and agree that policies built on the foundations of these principles and values would necessarily change the fabric of the American health care system. They suggest the following framework, starting from the premise that health care is a fundamental good. [This premise, however, is not shared by the interest groups who profit from the health care industry in the USA, and this factor was a major influence on the outcome of the reform attempts of the Clinton administration between 1992 and 1994] According to Brock & Daniels, the moral ideals of justice, equality and community require a health care system to be:

* **Universal** - everyone must have access to services without barriers;

* **Comprehensive** - the system must meet all health care needs;

and

* **Equitable** - health care services should provide equal benefits and reflect only differences in health care needs, not other individual or group differences.

Furthermore, the burden of costs should be spread across the entire community, and provision of services for all ages, across all generations, must meet the needs at each stage of everyone's life. A health care system must be able to control costs without lessening quality of care; to treat effectively and manage efficiently without wasting societal resources, and be simply organised for efficient management, thereby lessening
administrative costs, and ease of use by patients and professionals. In terms of accountability, patients should have free choice of doctor and an input to the decision-making process; providers must have clinical autonomy and the health care system must protect and preserve the integrity of the professional-patient relationship.


At the National Level (Macro level)

1. Public funding, whether through taxation or insurance, is bound to be a major source of finance for health care in order to ensure access and equity. Government should accept that it is publicly accountable not merely for the amount spent from public funds but for what those funds secure in health care.

2. The health services should meet reasonable need, and government should state explicitly what sort of needs can be met from the volume of resources it determines should be spent on health care.

3. Political accountability should be discharged in a principled way - for example, in terms of the principles of beneficence, non-maleficence, autonomy and justice.

4. Government must persuade as well as decide, educate as well as allocate, in seeking to promote and protect the nation's health.

The following checklist of questions arises from these principles:

1. What principled basis is used for determining total spending on health care within the public budget? What would be the effect of (say) a 10% increase or reduction in public funding?

2. Which groups have been involved in reaching decisions on spending? Which groups ought to be involved? How do you know that the amount spent is what the public wants? Have you calculated the opportunity cost to the health services of giving priority to other, non-health items, in the public budget?
3. Is there a responsible agent of national policy with a clear view of desirable and attainable standards of service in the main areas of spending? How is that view communicated to patients, providers and the public?

4. When deciding on the scale and pace of change in levels of funding and levels of health care provision, have you assessed effects in terms of autonomy, non-maleficence, beneficence and justice?

5. Do you have a means for ensuring that new procedures represent good value for money? How do you estimate established procedures whose value is low?

6. Under existing arrangements, what are the least satisfactory aspects of health and health care? Who is losing out? What lines of action might offer greatest gains in relation to these problems?

7. Do you have a mechanism for improving your decision-making if any of the above answers is inadequate?

At the Institutional Level (Meso Level)

1. Accountability is best discharged by means of due process, in which deficiencies and disagreements are acknowledged, and people accept that the way in which decisions are reached is competent and fair.

2. There should be a persistent attempt to improve procedures and structures of decision making, and explicit criteria for judging improvements should be formulated.

3. Organisational morale should be sustained, and good performance should not be penalised.

4. Health care should be seen as a response to need, and there should be a progressive attempt to eradicate shortcomings.

The following checklist of questions arises from these principles:

1. Which groups will gain or lose by the decisions you are making on allocation? Are these gains and losses consistent with the principles of autonomy, non-maleficence, beneficence and justice?

2. How do you make your criteria of choice publicly understood?

3. How do you ensure that changes in service levels are economically effective and equitable?
4. How does your performance compare with other similar institutions? Do the differences provide pointers to improvement?

5. How do you safeguard clinicians' autonomy (responsibly exercised) and users' choice?

6. What evidence do you have that the services provided are effective? What are the principal unmet needs, for which groups of people, and what could be done about them?

7. What can be done to improve your decision-making and your public accountability? Do you have a formal means of assessing these from an ethical standpoint, for example, an ethics committee?

At the Individual Level

1. All involved in health care must recognise that resources are limited, so that there must be an ever-present concern for effectiveness and efficiency.

2. Providers should be open to peer challenge and audit if they are to discharge their duty of accountability.

3. Providers must respond to the patients' and consumers' reasonable demands for improvements in the quality of care.

4. Patients and citizens should recognise that they carry responsibility for their own well-being in partnership with providers.

The following checklist of questions for clinicians arises from these principles:

1. How far do you press the sectional interests of your specialism against the overall interest of health care?

2. Do you know what are the total costs of your practice, and what each major type of therapy costs?

3. What is your evidence for assuming that your therapies are effective, and how regularly do you review this evidence?

4. How do you decide whom not to treat?

5. Do you treat like cases as like without resort to irrelevant criteria such as occupation, race and gender?
6. When you are dealing with one patient, do you take the needs of others into account and in what ways?

7. Could you explain matters more clearly to your patients and their families? Do you always work to increase their understanding and their ability to make their own informed choices?

8. Do you play an active part in peer audit and review? What else are you doing to improve your clinical practice?

The following checklist of questions for citizens arises from these principles:

1. If you are a member of a community health council, do you consider the problems of matching resources to improvements in services?

2. If you are a member of a group concerned with specific patient needs, do you press the interests of your group to the detriment of others?

3. As a citizen, do you keep yourself informed about health care issues, and is your concern properly reflected in your political choices and activities?

4. Do you accept responsibility for your own health, so that you do not increase the risk of unnecessarily demanding resources that could be used for others?

4. Ethics and Competitiveness

The current reforms to health care systems are underpinned by the philosophy of competition. In a competitive environment, the ethos of cooperation which had previously imbued health care at the meso and micro levels is very likely to be undermined. In a cooperative environment, sharing of information occurs, whereas hospitals which have to compete with each other may not be so willing to share what will become commercial data. Where clinicians are self-employed in the private-sector, they are not accountable to any regulating body in terms of quality of care provided to patients. Medical Boards may oversee the regulatory aspects of registering qualified medical personnel, and there may be a consumer complaints unit to which patients may
provided to patients. Medical Boards may oversee the regulatory aspects of registering qualified medical personnel, and there may be a consumer complaints unit to which patients may address their concerns; otherwise, patients must resort to the courts for redress of their grievances. Clinicians employed in hospitals must answer to hospital boards of administration and medical advisory committees for matters of complaint, but generally speaking, clinicians are not accountable for their quality of care unless it falls below a certain peer-accepted standard. Clinicians do not like to criticise their peers for choice of treatment therapies, the handling of cases and matters concerning medical judgment, and there is a public perception that clinicians, like lawyers, defend their own against outsiders, that is, their clients and patients. Hospitals may be accredited, but this is usually a voluntary procedure, and accreditation bodies do not mediate with unhappy consumers of health care. Private hospitals have their own commercial associations, and public hospitals may be answerable to government administrations, but patients-as-consumers need to seek legal redress for any perceived wrongs. From an ethical point of view, this leaves the patient at the mercy of professional decision-making, relying on the fiduciary nature of the doctor-patient relationship, and without the normal elements of a competitive transaction, such as knowledge by which to judge whether or not the doctor has the required knowledge, competence and skills. Many patients complain about the way in which they have been treated by their doctor, (e.g. in a rude or brusque manner, etc.), regardless of the doctor's ability and the fact that remedy has been effected. In Australia, while patients may choose any clinician, doctors are not permitted to advertise in any way which
outcome. In the UK and NZ, patients must register with one GP, although they may change doctors if they wish. In the USA, managed care institutions give their 'clients' (patients) a much more constrained choice of doctor.

Difficult questions must be raised in connection with the appropriate roles of private industry and the market economy in the provision of health care in each of the five countries under review. Such questions include the following which the Editor of Social Science and Medicine (1993, 36(12): iii-vii) puts forward as requiring ethical consideration in the reform process being undertaken in a competitive environment:

* What is the ethical basis of having different levels and standards of care for different segments within a given society?

* What are the partnership possibilities between private sector roles and those of voluntary and public sector health care provision?

* What is the role of multinational drug companies, and what are the ethics of drug research, production and pricing?

* Is the use of high technology for the benefit of the few or the many?

* Who decides access to technology - for whom, on what basis, and when?

* What are the ethics of deciding, in conditions of constraint, whether limited funds should be spent on provision of high technology for the few or less sophisticated technology for the many?

*What is the role of the health professional in relation to the guarantee of ethics, accessibility and equity in health care?

These questions show the range of factors and depth of analysis required by policy makers when considering both implementation of health care reforms which are underpinned by competitiveness, and the evaluation of those reforms in terms of equity.
5 Equity in the Provision of Health Care

Most of the values and principles outlined above can be accepted and readily identified by most people, even if the priorities in their importance differ. The concept of equity, however, can mean very different things to different groups. Brown (1991 p.654) has stated explicitly that the politics of health policy are stalemated in the USA partly because no widely shared agreement on the meaning and claims of equity has yet emerged. Dougherty's values (see above) are not held by everyone in the USA: for example, his second intrinsic value of caring in the therapeutic relationship would require the protection of the vulnerability of the patient and support for the fiduciary responsibilities of physicians. This would mean the realisation that medicine is not a commodity produced and sold for profit. This current perception has resulted in a product-liability mentality in the public and has exacerbated the malpractice liability problem. Patients sue doctors, and doctors respond by practising defensive (and therefore expensive) medicine. This would have to change, as would the practice of third-party payers having to agree to the therapeutic regime prior to treatment. The first intrinsic value would necessitate a right of access to basic care, and defining basic care would set the moral limits of what government must provide or subsidise to everyone. There are many problems, however, in defining a core of basic care, as evidenced by the attempts in NZ and American State of Oregon. (Beecham 1996a; Cummings 1994; Cotton 1992)

Mooney (1987) argues that there is a need to be more explicit about what health policy is, or should be, attempting to achieve as an equity goal. His examination
of policy statements on equity from national governments reveals difficulties in clarifying the meaning of equity, and he notes that not even the World Health Organisation (WHO) is consistent or clear about equity in health care. (Although see below Whitehead (1992) where clearer WHO definitions are cited) He argues that, while there is no single, uniquely correct answer to the question of what equity is or should be, the process of discussing and highlighting the different ways of looking at equity should help to make the choice of equity definitions, dimensions, goals and measurement more rational. Mooney's examples clearly show the problem:

"If equity is being measured as equal health, there are obvious difficulties in measuring health even before determining whether its distribution is fair or unfair: If we standardise by age and gender, how different can health status of an octogenarian male be to be considered 'fair' vis-a-vis the health status of an 8 year old girl? ... Should middle-class, city-born bred and educated doctors be left free to decide where to practise or be compelled, cajoled or given financial incentives in the cause of equity to work in a remote village or urban slum?" (Mooney 1987, p.297)

Mooney discusses the key issue of whether to adopt a 'demand' stance, involving the preferences of the patient, or a 'need' stance, which is based on the value judgments of health-care professionals. While it is possible from the philosophical standpoint of utilitarianism to pursue equity in terms of demand, "the very nature of equity as a social as opposed to an individual phenomenon points to the adoption of some social view of need in any basis for defining equity." In an editorial in Social Science & Medicine, Mooney (1994) points out his concern that, because much health economics research is data- and measurement-driven, the resultant quantification is too narrowly focused. Thus equity is defined in research in terms of equal health and of equal use because these can be measured more easily than can equal access, which seems to be the most
common policy goal. Equity in the provision of resources becomes even more important and problematic in times of economic shortage and budgetary restraint, so that available resources must be stretched further and further, with the result that the allocation process becomes a type of rationing process. Rationing in most countries has been covert up until quite recently. Ranade (1994 p.43) describes the UK's NHS as rationing by 'deterrence, dilution, diversion and delay'. In the USA, rationing is simply determined by price - if you can't afford health care you don't receive it.

"A further dimension to the ethical struggle of allocating resources for health care derives from the fact that definitions of utility, the good that we are trying to achieve and distribute, are by no means universal. The resulting situation can border on anarchy in a society where no effort is made to reach a public consensus about the society's core values. We assume, at our peril, that our definitions of equity have universal acceptance. In truth, they do not." (Leeder 1992 p.9)

5.1 Horizontal and Vertical Equity
In terms of clarification of concepts, it is important to specify precisely what is meant by equity - equity of what and among whom - in order to derive appropriate policy conclusions for pursuing equity goals and to identify potential policy conflicts where more than one equity goal is being followed. Also, equity and equality are not interchangeable terms. Equality is about equal shares, equity is about fairness, and it may be judged fair to be unequal. For example, it may be more equitable for groups who are more likely to be ill to have greater access to services. Thus we need to distinguish between horizontal and vertical equity. Horizontal equity is concerned with equal treatment for equal need; vertical equity with the extent to which individuals who are unequal in society should be treated differently. In terms of the financing of health care according to ability-to-pay, vertical equity is the requirement that persons or
families of unequal ability-to-pay make appropriately dissimilar payments for health care, and horizontal equity is the requirement that persons or families of the same ability-to-pay make the same contribution. (Wagstaff et al 1992, p.371)

According to Whitehead (1992), equity is concerned with creating equal opportunities for good health status, and with bringing health differentials down to the lowest possible level. Thus the three criteria for equity in health care according to Whitehead and the WHO are:

1. equal access to available care for equal need;
2. equal utilization for equal need;
3. equal quality of care for all

The extent of the differentials in health status between socio-economic groups has been noted elsewhere. Whitehead notes that the bias against many groups in society in terms of greater illness being associated with poverty and other disadvantage offends against people’s sense of fairness and justice. She points out, however, that discussions on equity often confuse the inequities in firstly the level and quality of health of different groups in the population, and secondly the inequities in the provision and distribution of health services. In the first group, not all differences in health status are inequities. The term ‘inequity’ has a moral and ethical dimension, and refers to those differences which are unnecessary and avoidable, and are considered to be unfair and unjust. Thus, to describe some situation as inequitable, the cause of the difference has to be examined and judged in the context of the society.

Culyer and Wagstaff (1993) look at equity and equality from the health economists viewpoint, and would disagree with the three principles outlined by
Whitehead. They note four definitions of equity in health care, which they contend are mutually incompatible, generally speaking:

1. Equality of utilisation
2. Distribution according to need
3. Equality of access
4. Equality of health

These health economists favour equality of health as the dominant principle, grounded in a more general and fundamental egalitarian objective of ‘equal flourishing’, and that equity in health care should entail distribution of care in such a way as to get as close as possible to an equal distribution of good health status. One logical conclusion to this argument, however, is that, given the finite resources available, ‘equality of distribution’ may well mean the lowering of health status to an ‘equal flourishing’ of lower-than-optimum health status.

The issue of equity and equality in terms of impact on health care policy-making is extraordinarily complex, and the literature from moral philosophy and health economics complicates the situation because it has yet to find a common language. The two disciplines appear to be talking at cross purposes, confusing normative ethical considerations (such as everyone in a society ought to be able to access the health care system to obtain health care within given parameters as determined by that society) with quantitatively derived economic principles such as ‘access as foregone utility’. [This latter principle is described by Culyer and Wagstaff (1993, p444) as being a measurement of health care consumption in utility terms rather than money terms.] It is clear, however, that great care needs to be exercised in the interpretation of criteria, because differences or variations in access, utilization and quality may not be
inequitable. Solving problems of inequity cannot be achieved by one level of organisation or one sector, but must take place at all levels and involve all stakeholders. As Mooney asks: What then is the meaning of equity in health care? (1987, p.302) There are so many different definitions and dimensions, and which ever is chosen will be a value-laden decision. As Mooney points out, most of the theories tend to emphasise equity in terms of access, rather than health or health care consumption. But whichever is chosen, it is paramount that the definition is clarified so that the policy objective is quite clear. The definitional problem of equity underlines the requirement for health care policy makers to include ethical dimensions in the debate for health care reforms. As provision of health care involves a fundamental moral issue of how society treats its citizens, especially those least able to defend themselves, health policy cannot be reduced to a purely rational technical process, (e.g the use of QALYs, etc.), even if the means were available. There are some who envisage that the outcomes movement within health care may provide such means; but outcomes results (e.g. from meta-analyses of random controlled trials) can only inform the debate and democratise the values. Results from outcomes research will hopefully provide better information, but this is not guaranteed, nor will this type of information help in the conflict between individual and collective good. Debate is required on what is a socially-just basis for valuing states of health; whose values count; and whether there is any ethical justification for barring some individuals (e.g. smokers, drinkers, sportspeople) from health care. (Ranade 1994, pp.41-43)
6. Equity and Access

The strong correlation between lower socio-economic status and ill-health status which holds true for all countries appears to point to, among other things, a lack of equity in access to health care in all systems and a variance of quality in health care between different groups. Morbidity and mortality rates are higher for indigenous peoples, low wage-earners, single families, the unemployed, the disabled and rural dwellers. Equal access to available health care may stand alone as an equity principle, or may be combined with another principle such as ‘equality of access for equal need’, as promoted by WHO. While equal access is deemed an attribute of the systems in Australia, New Zealand, Canada and the UK, there are many impediments in its practical application. In the USA, equality of access pertains to the federally operated health systems, but the same barriers apply. In any country the most obvious barrier is the unequal geographical distribution of health care resources and facilities. Rural areas cannot sustain teaching hospitals, for example; other services may not be available because it would be economically inefficient to supply them. Procedures are required to try to balance the unfairness of the situation, (e.g. provision of flying doctors in outback Australia). Such schemes as paying for patients' travel expenses from country to city (such as the patients' travel assistance scheme (PATS) in Western Australia) help to redress the imbalance. At the individual level, if patients are not close to public transport, they may not be able to avail themselves of health care services. Access is effectively denied them. In systems which are free-at-point of entry, such as in Australia, UK and Canada, patients may be denied access if the medical
practitioner does not bulk-bill, or does not otherwise charge the government directly for the patients' costs. Thus patients who have to pay the doctor first, prior to obtaining reimbursement, may not be able to afford access to the system.

At the system level the infrastructure may not be able to cope with demand: if there are no empty hospital beds available, prospective patients cannot access the system. Waiting lists, closed wards and operating theatres, insufficient staff and inadequately maintained equipment are other barriers to access for patients in public systems. In the five selected countries, health care resources are primarily distributed to the hospital sector, with high technology medical services obtaining probably a greater than fair share considering the numbers of patients treated, leaving the majority of patients - the chronically ill and those needing the less heroic forms of treatment - with insufficient resources and therefore ineffective access to the system. Daniels (1982) has noted the fact that access to health care is usually assumed to mean access to whatever range of services is available in the system, which ignores the non-homogeneity of function of health care services and systems. By contrast, the approach which utilises the 'decent basic minimum' principle may avoid this objection; but this approach has a major problem, mentioned above, in defining what is meant by basic minimum, or a core set of services. Daniel's answer to this, however, is to assume that only some of the functions served by health services give rise to social obligations to provide them; the health services to be provided as a decent basic minimum are those which meet the health care needs of individuals as judged by their impact on the opportunity range of those individuals. The opportunity range is the array of life plans
that it is reasonable to pursue within the prevailing conditions of a society. Thus similar impairments of normal life may well have different effects on the opportunity range of individuals within different societies, but within any specific society, it should be possible to rank the effects of different impairments in terms of their normal opportunity range. This in turn allows a crude ranking of the importance of different health care needs.

7. Equity and Efficiency

The administrative reforms of public bureaucracies throughout the western world in the 1980s and 1990s concern the quest for economic efficiency. But as Goodin (1988 p.256) notes in relation to the welfare state, it is simply wrong to think that economic efficiency is itself of any ultimate moral importance, except in so far as it may be immoral to squander a society's resources by being inefficient. In health care policy especially, the allocation or distribution of resources for health care must be guided by principles of social justice, equality, and equity even though it is extremely difficult, as discussed above, to clearly define such concepts. Fox (1979), in a paper examining the role and influence of economists and economics on the public discussion of health policy in the USA, notes that social scientists, while becoming more respected in their disciplines and more acceptable to physicians, at the same time have become less concerned with equity and social justice. Fein (1979) concurs with Fox, and warns of the dangers of looking to economics and economists to provide policy prescriptions for decision-making by organisations (including government) whose concern is with equity and distributive justice issues. The economist's narrow efficiency focus contributes to a
distorted view of society, where technical, not political answers are called for, based on efficiency not on considerations of social justice.

"Nor should we imagine that the balance between efficiency and equity is redressed by reference to human-capital theory and cost effectiveness or benefit-cost analysis. Useful as these approaches are, they do little justice to questions of distribution, 'fairness', 'equity' or 'social justice'." (Fein 1979, p.355)

Fein's argument is to form policies on humanitarian grounds, with resulting programs being judged by the economic merit of each. Those programs having more economic merit would have priority. The problem comes when efficiency and social justice considerations conflict - what if health care is a 'poor investment', as it may well be in dealing with the very old or the very young, or the very ill with only a limited life span left.

"Unless the limits of economics as it is generally practiced are understood, decision makers may come to think in the same limited patterns of thought in which economists think. .... If we economists fail to recognise the current limitations (and implicit values) of our discipline, there is the danger that non-economists, dazzled by our techniques and subject to our complaints that we aren't listened to, will come to think only about the things we think about. And there is much to think about beyond efficiency." (Fein 1979, p356)

In an effort to reconcile, to a reasonable degree, the conflicting goals of equity and efficiency, Alain Enthoven proposed the concept of 'managed competition' which would use competition to create incentives that promote quality and economy in the organisation and production of health care services, and to structure cost-conscious consumer choice in the pursuit of equity and efficiency. (Enthoven 1988.) Pereiras (1993) showed how equity and efficiency are intertwined in some of the distribution principles, and as Light (1992) points out,
"In the swirl of political rhetoric and economic concerns, the relations between equity and efficiency are often miscast. Depending on the issue and the context, they can be intertwined or quite separate."

Watt & Sheldon (1993) note that resource allocation in the NHS in the UK is notionally based on the twin principles of equity and efficiency, taking into account the distribution of health care needs and the costs of meeting those needs. This is in agreement with Pereira's contention that it may well be that the overall aim of medical care is indeed health maximization but that specific provision arrangements, such as UK's NHS, have adjacent objectives (such as guaranteeing equal access for equal need) which take precedence in any eventual trade-off. (Pereira 1993 p.37) In the UK, the Resource Allocation Working Party (RAWP) asserts in its terms of reference that an objective of the NHS is:

"to reduce progressively, and as far as possible, the disparities between the different parts of the country in terms of the opportunity for access to health care of people at equal risk."

Carr-Hill and Sheldon (1992, p.117), however, have described how the apparent move towards rationality (which in itself is a troublesome concept) in the allocation of resources in the NHS using statistically based formulae is illusory.

"This is not just a technical problem of poor application of statistical techniques. The basic problem is to find a combination of factors reflecting dimensions of need and then appropriate weights with which to combine them within the context of the guiding principles of equity and efficiency."

These researchers view efficiency as the 'maximum output possible given the resources available', but see problems with the approach which argues that resources should be allocated so as to equalise marginal met need. This approach assumes that comparisons can be made between the health service responses to different presenting
conditions or types of need. Some combination of equity and efficiency criteria, given a minimum baseline, should guide the allocation of resources both geographically and between services. As Carr-Hill & Sheldon (1992) view the problem, the issue is how to adjust for the variations in the need for health care of different groups, given the lack of a model to measure need. They worry that, until more valid evidence about the variation in health care needs or demands of populations is available, "the use of statistical techniques may serve only to obscure the lack of knowledge." As Watt & Sheldon (1993) note, in terms of rural health care provision, equitable treatment will only be possible at the expense of efficiency. This will be true in other sections of the health care system also.

The current reforms are intended to improve the performance of health care systems in terms of equity and efficiency, but, as pointed out in an editorial in *Social Science & Medicine* (1994; 38(1): p.vii), despite three decades of health economics, there is little evidence to suggest which model is to be preferred and in what circumstances. Furthermore, there are few rigorous comparative studies made, and, while the concept of efficiency at the micro level has been extensively researched in the rapidly growing economic evaluative literature, at the macro level clear operations of the concept are lacking.

8 Health Insurance and Concepts of Social Justice

Health insurance as an economic mechanism is one means by which governments can improve the access to health care and the equity of its provision. In the interests of equity, cross-subsidisation using community-rating of bad-risk groups by good-risk
groups must be inherent in the scheme. The following classification of health insurance schemes is from *Characteristics of Health Finance/Insurance Systems (in OECD countries)* (OECD 1994b, p.16, 17.)

8.1 **Private Insurance**

Such systems cover individuals or groups, setting premia on the basis of their risk characteristics. They are flexible, providing a range of insurance packages with different degrees of risk. High-risk individuals find it difficult to obtain cover. In the USA private insurers cover major health-care risks for the bulk of the population, but in most other countries private schemes can complement public schemes at the margin. In the other countries, supplementary insurance is available from private insurers or ‘friendly societies’ to cover patient cost-sharing (user charges) in state schemes for better physical surroundings (private rooms), and for care as private patients of hospital specialists (e.g. UK, Australia) or for risks not covered by state insurers (e.g. Canada and Australia). In some cases these premia are tax deductible, which provides an incentive for private health insurance.

8.2 **Social Insurance**

These systems are based on statutory sickness funds most often governed by the social partners and overseen and tightly regulated by the government. Risks are pooled in the fund and premia are income-related over some range. Premia sometimes vary across funds to allow for differences in risk structure of the membership; in some cases, these premium differences are offset by government support or transfers from their funds. Membership is compulsory for certain groups (e.g. those with low incomes) and in
some cases cover virtually the whole population. Table 8 shows the extent of social insurance coverage in Australia, UK, New Zealand, Canada and USA, by listing the services excluded.

<table>
<thead>
<tr>
<th>Country</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>Medicare (Parts A &amp; B) excludes long-term home care, out-patient pharmaceuticals, routine eye care and dental treatment; for private schemes exclusions depend on insurance policy held.</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>Dental care and optical care (except for low income groups), low cost pharmaceuticals.</td>
</tr>
<tr>
<td>Canada</td>
<td>Sanatorium, out of hospital dental treatment, non-hospital pharmaceuticals (some exceptions for older persons), varying degrees for prostheses, spectacles and hearing aids and treatment in privately owned hospitals.</td>
</tr>
<tr>
<td>Australia</td>
<td>Dental care (limited for specific groups), pharmaceutical’s (some subsidies).</td>
</tr>
<tr>
<td>New Zealand</td>
<td>Ambulatory care for higher income groups, dental care, glasses.</td>
</tr>
</tbody>
</table>

Source: OECD 1994b, p77

8.3 Tax Finance

There are two types of tax finance systems. In the first, the state insures and supplies health care in the same organisation and finances it as part of the budget. However, responsibility of production/provision is often delegated to lower levels of government
(Italy, UK [until recent reforms], Denmark, Finland, Greece, NZ [until recent reforms], Norway, Spain and Sweden) Alternatively, in some countries (Canada and to a lesser degree Australia) the government acts as a single insurer raising the necessary revenue through the tax system and paying largely private (mainly non-profit) suppliers.

8.4 Population coverage

In the USA, despite several programs covering 24% of the population - mainly Medicare for the retired and Medicaid for some groups of the poor - around 15% of the population does not have insurance. A significant number do not have as much insurance as they would like, or they temporarily lose insurance in between jobs. For some, insurance is available but the cost is so high, that they have decided (or been obliged) to self-insure. This does not necessarily mean that they do not have access to health care as many are treated in public hospitals, but the amount and quality of care is lower.

8.5 Risks covered

There are relatively modest differences across countries in the risks covered. For the USA this concerns Medicare and Medicaid only. For private insurance, the diversity of the system makes it difficult to characterise. All countries provide coverage for hospital and ambulatory care. Under state systems, this package is generally defined by law and the procedures covered have been progressively widened over time as new medical technology has appeared and been incorporated into accepted medical practice. Greater differences exist in the area of drugs, dental care and prostheses, eyeglasses and hearing aids, for long-term care and rest-homes, and sanatoria.
8.6 Cost-sharing by patient

Co-payments vary depending on the type of service. In Australia, private insurance for the co-payments for ambulatory care is not permitted, nor for the gap between hospital care fee schedule charges and actual charges, even though public patients may receive the same treatments and accommodation free of charge. Table 9 shows cost sharing in Australia, UK, New Zealand, Canada and USA.

<table>
<thead>
<tr>
<th>Country</th>
<th>GP</th>
<th>Specialist</th>
<th>Drugs</th>
<th>In-patient</th>
<th>X-Ray, Path</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>United States</strong></td>
<td>20% in excess of the $100 deductible</td>
<td>100%</td>
<td>$676 deductible first 60 days</td>
<td>Same as doctors</td>
<td></td>
</tr>
<tr>
<td><strong>United Kingdom</strong></td>
<td>None</td>
<td>None</td>
<td>$4-5 per prescription or 'free with season ticket of $65. Many persons exempt</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td><strong>Canada</strong></td>
<td>None</td>
<td>None</td>
<td>Discretion of Provinces</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Australia</strong></td>
<td>For 25% of bills average of $5</td>
<td>For 71% of bills average of $8</td>
<td>Maximum $11 per prescription</td>
<td>None</td>
<td>Included in specialists' bills</td>
</tr>
<tr>
<td><strong>New Zealand</strong></td>
<td>Extra billing</td>
<td>Out-patients $3 - $17</td>
<td>$2 - $8 with stop-loss</td>
<td>None</td>
<td>Out-patients $3 - $17</td>
</tr>
</tbody>
</table>

1 Approximate amounts in US dollars, converted at nominal exchange rates
2. Lower deductibles if in HMOs
Source OECD 1994b p.78
9. Rationing Health Care

Rationing has always been high on the policy agenda because of the continuing imbalance between demands and resources, and is becoming more explicit because of pressures on systems to cope with growing demands from an aging population and from the public in general who are more aware of treatment options and possibilities. The debate on rationing, (or ‘priority setting’, which is considered to be a less emotive term) has begun and is gathering momentum, with a movement towards public involvement in priority setting in the allocation of health care resources. (Smith 1995, 1996b) Some health care reforms, such as the funder-provider split imposed in UK, NZ and Australia, have exposed rationing processes to public scrutiny. While the basic problem underlying these decisions is thought to be economic, it is in reality ethical because choices are based on some moral assumption that competing claims can be adjudicated fairly. Therefore, explicitly or implicitly, choices must be based on the values of a given society.

9.1 Approaches to Rationing

There are several approaches to rationing. At the macro level, policies can exclude certain groups of people, or certain treatments. At meso level, guidelines for the treatment of specific conditions and the provision of different services operate to exclude costly interventions or diagnostic procedures. Certain expensive technologies, such as MRI machinery, may be denied to hospitals. Then there is the ‘muddling through’ type of rationing approach, where, particularly in the UK, local authorities apply their own interpretation of national policies. This last approach may possibly be
the best, given the multifactorial situations which may present to the attending clinician. (Ham 1995) What seem to appear as givens in the situation, but which should be the subject of analysis and debate, are:

1. That the expectations held of the health care systems are valid and reasonable; and
2. That the allocation of resources at macro level, expressed as a percentage of a country's GNP, cannot be varied.

Many of the expectations are not reasonable: there is the expectation that medical science will one day make death a non-certainty, and that research should be aiming for this objective. As Annas (1994) observes in the USA, both society as a whole and physicians as a group, remain unable to accept death and thus appear unable to satisfactorily deal with the physical, psychological, and spiritual approach to death. This view is probably valid in other countries also, and the outcome is heroic technological efforts to stop death at any price. In the meantime, clinicians are expected to do everything in their power to stop the process of aging and the onset of disease. There still exists the expectation that the clinician will be able to save lives in the direst circumstances: there is still the belief in the 'magic bullet'. (Bosin 1992) That clinicians can perform miracles is an unrealistic assumption, yet it is widely held. When an outcome is less than satisfactory, the patient blames the clinician. There is no recognition of the fact that bad outcomes need not necessarily be anyone's 'fault'. The search for immortality, or at least the elixir of youth, is still part of the human psyche; the translation into expectations that public health care systems will somehow provide the wherewithal to realise these fantasies is straining all health care systems. It is to be hoped that with the movement towards the involvement of the public in priority
setting, some of these expectations will be revealed and will be rebutted. Governments should stop inducing in the public false expectations, such as the unlimited availability of publicly provided health care as in Australia.

The second point of allocation of resources at the macro level can be viewed from two perspectives. More resources after the \( n \)th dollar allocated to the health care sector may or may not improve the overall health status of the country, given the theory of diminishing returns. The problem is deciding on the amount of \( n \), which clearly should be associated with health care need. (Donaldson & Mooney 1991; Eyles & Birch 1993) If it is assumed that the current resources are being spent efficiently and effectively, then more of the same would improve the health status only if there is unmet need existing. This cannot be accepted or denied with any confidence at present, as information about need, unmet need (e.g. hospital waiting lists) is either unavailable or is suspect as to its reliability and validity. The other viewpoint argues that resources currently allocated to health care at the macro level may do more to help the health status of the country if they were redirected to other areas, to provide better housing, sanitation or economic opportunities (e.g. employment) to those with low health status. Until these issues form part of the health care reform debate, questions will concentrate on what services to provide, to whom, and by what method? By posing these questions in this manner, the answers must address the negatives, i.e. these services will not be provided; these groups of people will not receive such and such a service; these services will not be free. (e.g. see Levinsky 1990 on age as a criterion for rationing health care.) In other words, rationing.
9.2 Questions to Drive the Allocation Process

The central questions to be asked are: what are we buying with our health care resources, and, what is the relationship between expenditure and the population's health status? (More detailed questions are listed in Weale's recommendations above.) Policy makers trying to reform their health care systems should be asking three basic questions in the context of an ultimate objective, the answers to which ought to drive the allocation process:

1. Who is covered?
2. What is covered?
3. How is it to be financed and delivered?

The ultimate objective ought to be the improvement, maintenance or restoration of health of all citizens. All other objectives, such as reduction of costs as a major barrier to access, equitable distribution of health care, universal coverage, efficiencies in provision, etc., are all means to that end.

In the USA, the primary question is WHO is covered; in the other four countries, national health coverage allows priority setting to concentrate on WHAT is covered, although it is important to ensure that the principle of universal coverage in these countries is, in fact, maintained. Barriers to access may erode the principle; for example, while citizens have access to health care in terms of not having to pay for care, waiting lists may be effective barriers to the receipt of that care when it is needed.

i) Coverage for What?

This issue is, or should be, at the heart of the debate on rationing or priority setting. There are many calls for 'basic care' or 'comprehensive' care for all, or a minimum set,
or basic core of services, but the defining of such sets of services is extremely difficult. (Cotton 1992) No one has come up with a process by which such sets could be defined, although as noted above, attempts have been made. A committee was appointed by the government in New Zealand to define a core set of services. (Cummings 1994) However, the committee decided that rationing by exclusion, Oregon style, was neither helpful nor desirable. (Ham 1995) In all countries, it has been easier to single out groups of people who will/will not receive certain services. (see Beecham 1996a; Gerard 1993 for the UK) The aged are singled out to the extent that there is now debate about 'age-ism' and discrimination likened to racism and sexism. (Evans 1993; Levinsky 1993) It is also easier to itemise services which will not be provided by the public purse: tattoo removal, in-vitro fertilisation programs, cosmetic surgery, etc., even though some patients may require such treatments for their well-being, i.e. be in medical need.

ii) Methods of Rationing

The method by which priorities will be set depends on the objective(s) of the health care system. If it is accepted that the major objective is to ensure a certain standard of health status in the community, then needs for health care services will be concerned with

1. the maintenance function to keep a given standard;
2. the preventative function to stop the standard being eroded; and
3. a repair function, to bring patients back to the health status required.

Choosing priorities at the macro level involves balancing these needs. From a cost-effectiveness perspective, there is an argument that both the preventive and
maintenance functions should be accorded higher priority than is the case in most health care systems, which currently allocate the greatest proportion of resources to the repair function. (Brown, Viscoli & Horowitz 1992; Freeman 1995; Russell 1993; Schaufller & Rodriguez 1993)

The standard of health status required must also be defined. If it is accepted that the ability to function normally is the standard, then needs for health care are related to the threat of restricting this functioning. ‘Normal functioning’ can be viewed from the perspective of three groups of stakeholders in any health care system:

1. the community,
2. the providers of health care, who each will have a particular notion of the criterion of effectiveness of each treatment for each patient; and
3. individual patients, each of whom will have a notion of his or her own ability to benefit from (demanded) treatment.

The individual perspective must allow for the wide variation between people, resulting in a very broad definition. The medical approach defines health as the absence of disease, which may often neglect the psychosocial functioning of individuals and their social circumstances. From a community perspective, health is the possibility for every member of society to function as normally as possible, and includes all categories of people. The priorities of health services, which would include long-term care for the elderly and care for the mentally-ill, would be chosen by consensus. The Oregon experiment and other public surveys, however, have shown how very difficult this task is. (e.g. see Heginbotham 1993)

At the meso level, health care programs are allocated resources, and at the micro level, individual patients either receive treatment or not, according to the forms
or mechanisms of allocation, and the priorities of allocation currently in practice. As pointed out by Sheldon & Maynard (1993), many of these rationing mechanisms are deployed in various, largely uncharted ways. The rationing process is implicit, and the providers who ration do not have their choices monitored and evaluated and are largely unaccountable for the ways in which funds are deployed. The results of unaccountable clinical discretion on the part of providers are major variations in practice and patient access. Until practices and treatments are evaluated, and their outcomes monitored, resources are likely to be allocated haphazardly and inefficiently, and in far too many cases, ineffectively. There is, however, a very fine line between evaluation on the one hand and interference in clinical autonomy on the other.

iii) Techniques of rationing

Methods of rationing can be described as either market or regulated (non-market) mechanisms. The market rations health care services to those who can pay for them. Health care insurance introduces a market mechanism into health care systems which are mixes of publicly provided resources and privately provided services. The leading contender for the principle to use in non-market situations seems to be the concept of medical need and the patient's capacity to benefit per unit of cost. Thus resources should be allocated where medical treatment is cost effective. This may be applicable at the individual micro level, but where does it leave preventive health services? It also brings into question the meaning of 'benefit': individuals may claim benefit where others will see none, thus bringing discrimination to categories of people such as the elderly, the young, the disabled, the mentally-ill and other groups. (De Fever 1994)
rationing is to be according to capacity to benefit per unit of cost, then techniques of
cost-effectiveness, and cost utility such as QALYs and related scales, will be the major
tool. (for cost effectiveness see Drummond 1987; Robinson 1993b-g; for cost utility
see Gerard 1992, 1993; for QALYs see Holmes 1993; Johanneson 1995b; La Puma
1990; Rawles & Rawles 1990; Schwartz, Richardson & Glasziou 1993; for HYEs see
Bleichrodt 1995; Culyer & Wagstaff 1995, 1993a; Loomes 1995; Loomes & McKenzie
1989) But as discussed above, there are questions concerning the moral justification
for using such econometric tools in such a sensitive area. (Hubin 1994; Johanneson &
Jonsson 1991)

9.3 Measurement of Health Benefits

Early efforts concentrated on measures of activity; now measurement of outcome is
required. This means both the length of survival time for patients, and their subsequent
quality of life. There are many questions requiring answers: Can longevity and the
degree of well-being be successfully combined into the units of ‘quality-adjusted-life-
years’ (QALYs)? Are measurements of well-being using a health index analogous to
units of weight, where two one pound units unambiguously equal one two pound unit?
Or are they more analogous to units of temperature, where two days with a
temperature of 15 degrees C cannot in any sense be equated to one day of 30 degrees
C. The answers are urgently needed, because already economists are attempting to
relate units of health care benefit to units of cost, to provide what can be called a ‘cost-
utility’ analysis. It will perhaps be even more useful to be able to balance generally
accepted units of well-being against measurements of risk associated with treatment, to
produce a 'risk-benefit' analysis. This is needed to put much publicised risks into perspective. (Teeling Smith 1987, p.8)

Given the movement towards the inclusion of the public in the process of allocating resources, other techniques will include consumer surveys. (Heginbotham 1993; Hibbard & Weeks 1987; Evers 1993; Pitt 1993; Pollitt 1988; USA Working Group on Managed Care 1994) Also required will be the scientific evidence from random controlled clinical trials and meta-analysis, so that effective treatments are identified. It is clear that all three types of information are required before equitable, efficient and effective allocation of resources can proceed. This information should be coordinated at the national level, even though much of the community information will come from the local level. National standards must be set and outcomes evaluated against health policy objectives, to inform the allocation/rationing process at the macro level. Until such time as costing information, treatment effectiveness knowledge and community values are known, rationing will most likely occur as a political function at macro level and be left to clinical discretion at the micro level. Clinical discretion may also have a distinct political component, as evidenced by the Australian Medical Association's Ethics and Professional Conduct Committee, which decided that it was not the role of doctors as patient advocates to make decisions between patients in order to determine access to inadequate resources. (*Australian Medicine*, 17 May 1993, p.8)

The Committee members agreed, however, that doctors may not always be able to secure access for patients to needed resources, which were controlled by government. The doctor's appropriate role then was to draw attention to the inadequacy of available
resources. Each time this is done, however, political opprobrium descends onto the profession and the public is encouraged to view clinicians as self-serving, greedy exploiters of the health care system. The ethical concerns of doctors are usually quite different to those of governments, sociologists or others.

10. Surveys of Opinion on Prioritising Services

Some surveys of both professional health care providers, administrators and the public have shown that some services may be suitable for explicit rationing. (Bowling 1996, Heginbotham 1993, Murray et al 1994) Surveys of the public need to be representative of the population at large, to ensure against bias in various categories, age groups, employment and other factors. The open forums conducted in the Oregon experiment attracted an unrepresentative sample, attendees of the meetings being mainly health care workers. People from the lower socio-economic stratum were not represented, yet these were the subjects of the endeavour to provide health care cover. Heginbotham (1993) reports on a health care priority setting survey of doctors, managers and the general public. The British Medical Association, The British Medical Journal, Patients Association and King's Fund collaborated in the survey. Question 6 in the survey asked: If you were responsible for prioritising health services, how would you prioritise the things on this list? Table 10 shows the results.

Heginbotham makes certain key points about this result. Firstly, there was complete agreement about the highest and lowest rankings - child immunisation and cancer treatment for smokers. As in similar surveys, ranking exercises produced substantial commonality in the top 10-15% of items and in the bottom 10-15% of items, whereas
Table 10
Prioritising Health Services

<table>
<thead>
<tr>
<th>Question</th>
<th>General Public Doctors</th>
<th>Rank Managers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening for Breast Cancer</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Heart Transplants</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Hip Replacement for Elderly</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Support for Carers of Elderly</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Education to prevent young people smoking</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Childhood Immunisation</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Care offered by GPs</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Intensive care of premature babies</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Treatment for Schizophrenia</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Cancer Treatment for Smokers</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

Source: After Heginbotham (1993), p.152

The middle groups of 70-80% of items show much greater variance, largely independent of the list length, content and preparation. But caution must be exercised in using this information, because immunisation is almost a 'given', and cancer treatment for smokers is almost deliberately pejorative in this context, inviting the concept of 'just deserts' to be applied. Secondly, the rank ordering given by the general public was less consistent with answers to other questions in the survey than that provided by doctors and managers. This must reflect lack of information, prejudice, the effect of media campaigns and differential awareness about cost-quality issues. An example of this is provided by screening for breast cancer. There is a gender-driven debate which places great importance on this service, but such screening programs are expensive per
life saved and thus tend to be accorded a lower rank by doctors and managers. Thirdly, doctors put preventive measures and quality of life measures consistently higher than interventions. Fourthly, the overall variance of the general public sample is less than half that of the doctors and managers, which suggests an uncertainty among the public and possibly a lack of key information. Doctors and managers have much more knowledge about costs and benefits of different treatments. Heginbotham suggests that the public should be more involved in setting broad criteria for decision-making and the decisions then left to those able to take an expert view based on more substantial and detailed information. However, this may lead to quality and fairness issues being relegated to a position below cost efficiency - a position which is in need of change.

Given the multi-faceted nature of the problems inherent in allocating equitably (in terms of social justice), and efficiently (in terms of cost-effectiveness), the resources for health care, van der Wilt's (1994, p.301) conclusion should be widely acknowledged: that procedures used to decide on the public funding of health care services should meet criteria of openness and accountability, to ensure that everyone has the possibility to check, and to challenge if necessary, the consistency with which general principles are interpreted and applied. This is the idea behind the State of Oregon's Basic Health Services Act, which set out a unique and highly visible process for setting priorities for health services, using cost-utility analysis and incorporating public attitudes and values. The planning and implementation of this experiment is described in the next section.
11. The Oregon Health Plan Experiment


"Oregon's priorities were set on the basis of broad consensus. The objective of health care reform, it was agreed, is to improve, maintain or restore health - not universal coverage, access to health care, or cost containment. A Health Services Commission was created to consider clinical effectiveness and, through public involvement, to attempt to integrate social values into the priority list. Oregon's legislature can use the list to develop an overall health policy which recognises that health can be maintained only if investments in several related areas are balanced."

Importantly, Kitzhaber's specific intention was to use the prioritisation process to create a state version of universal health insurance coverage not only for the Medicaid and working poor populations, but eventually for the vast majority of Oregonians. Although the program begins with the poor and the working uninsured, he saw the Oregon Basic Health Services Act as creating a model of prioritisation which would allow for universal access and cost containment for all Oregonians and eventually for all Americans. (Dougherty 1991, p.2) This was a valiant attempt, within the framework of health care reform in the USA, for the state to allocate public health care resources so as to provide all of its citizens with basic health care cover, an attempt Ranade (1994, p41) describes as "a bold experiment to use outcome data to determine priorities for state funding of health care."
11.1 **Process of Oregon Experiment**

The work of the Health Services Commission actually built on the experience and activities of a community grass-roots bioethics project known as Oregon Health Decisions (OHD), which had been holding hundreds of citizen meetings around the state to discuss health care and allocation issues. A Citizens Health Care Parliament had met in Portland in September 1988 and developed a set of public policy principles intended to be guideposts for the state legislature and other policy-makers concerned with health care resource allocation. The principles took into account the trade-offs between length of life and quality of life, efficiency and equity, and the cost and benefit of the service. The principles (15 in total) developed by this meeting had focused to a large extent on quality of life, e.g.:

*Principle #1.* The responsibility of government in providing health care resources is to improve the overall quality of life of people by acting within the limits of available financial and other resources.

*Principle #4.* Health care activities should be undertaken to increase the length of life and/or the health-related quality of life during the life span.

*Principle #5.* Quality of life should be used as one of the ethical standards when allocating health care expenditures with insurance or government funds.

*Principle #6.* Health-related quality of life includes physical, mental, social, cognitive and self-care functions, as well as a perception of pain and a sense of well-being.

In light of this work having been carried out over the previous decade, the HSC commissioned the OHD to be involved in the interaction with the public. The OHD was to hold a series of public meetings to discuss people's values concerning the outcome of care. (Hadorn 1991a) Not surprisingly, quality of life emerged from these meetings as a major priority to be considered in the rationing of any services, pointing to the requirement to consider the individual patient. But the Oregon HSC had initially
interpreted their brief as suggesting the use of cost-effectiveness principles, based on the utilitarian quest for the greatest good for the greatest number, for developing the priority list. As Hadorn (1991b) notes, this tends to devalue adverse affects of a policy on specific individuals. Initially, the HSC conducted a cost-effectiveness analysis, using QALYs, of over 1,600 health services ranging from appendectomies to treatment of colds and 'flu. By this method, the first 94 items on Oregon's initial list, released in March 1990, dealt with office-based visits, for often self-limiting conditions, while the more expensive but life-saving treatments such as appendectomies, were rated relatively low because of their higher associated costs. Serious flaws related to inaccurate cost and effectiveness data led to widely criticised rankings: reconstructive breast surgery was ranked more highly than treatment for open fracture of the thigh, and treatment for crooked teeth ranked higher than treatment for Hodgkin's lymphoma. Transplantation was again near the bottom of the list as was treatment for AIDS, and primary care was near the top. (Dixon & Welch 1991, p.892) This result was both counter-intuitive and negatively received by the public, to whom it was put for comment. As Hadorn notes (1991b, 1991c), the fact that cost-effectiveness analysis failed to produce a reasonable priority list has significant implications for future efforts to set health care priorities. The Commission had to abandon this method, and instead, developed from the overall list a set of seventeen health service categories, which described either a specific type of service, or more generically, the expected outcomes of care. These seventeen categories were then ranked in order of importance according to three subjective criteria: value to the individual, value to society, and whether the
category was deemed 'necessary'. The procedures for ranking treatments were complex and included telephone surveys of the general public to devise quality of well-being scores for specific outcomes and community meetings to assess the value attached to services. (Hadorn 1991c) Health insurance firms were asked to advise on the pricing of certain treatments, to gain more accurate data. Using both cost-utility and consensus approaches, the priority list was finalised in February 1991 and contained 709 condition-treatment pairs, subdivided into the 17 categories. The 17 categories were segmented into three groups:

Categories 1 - 9: Essential services
Categories 10 - 13: Very important
Categories 14 - 17: Valuable to certain individuals

Within each category the ranking of the condition-treatment pairs reflected the benefit likely to result from each procedure and the duration of the benefit. The high ranking priorities were:

* Acute, fatal conditions where treatment prevents death and leads to full recovery;
* Maternity care;
* Acute, fatal conditions where treatment prevents death but does not lead to full recovery;
* Preventive care for children;
* Chronic, fatal conditions where treatment prolongs life and improves its quality;
* Comfort care. (Kitzhaber 1993, p.44)

The final priority list was given to an independent actuarial firm for determination of the cost of delivery of each element on the list through capitated managed care. The list and the actuarial data were given in May 1991 to the Oregon legislature, which created a standard benefit package of the first 587 items on the list, and applied in August 1991 to the US Health Care Financing Administration (HCFA) for a waiver
which was required prior to implementation of the program. But the Bush Administration denied the waiver because of concerns that quality of life assessments were embedded in the prioritised list, possibly resulting in discrimination against the disabled. Oregon submitted a revised list in December 1992, which was accepted and a waiver granted, subject to 29 conditions of a technical and reporting nature, for the program to be implemented in January 1994. The state was also ordered to submit by May 1993 another priority ranking to ensure that persons with disabilities were not potential subjects of discrimination. The financial implications in the delays were that a budget of $34 million authorised by the state legislature in 1991 was now inadequate, as the costs had grown to $83.6 million to fund the 1993-95 biennium. This occurred at a time of a budget shortfall of $1.2 billion. (Campbell 1993)

Part 1 of the plan was eventually implemented in February 1994, and even its supporters were shocked by the demand. They had expected 13,100 people to sign up in the first two months, but in the first two weeks, there were 46,000 phone calls and 25,000 applications by mail. (Roberts 1994) Part 2 of the plan was to have all employers contribute towards insurance by July 1993, but because of the intense lobbying of small business to Washington, this part of the plan has been set back to 1998.

11.2 Results of the Process

Not only were Oregon's priorities explicit, so was the process used to identify them. Choices were based on systematic not ad hoc methods, making for more consistent decisions. The legislature is clearly and inescapably accountable not just for what it
funds in the health care budget but also for what it chooses not to fund. This kind of accountability is a major departure from the previous system. Oregon has shown just how much unmet demand there had been, and the fear is that costs have been underestimated. In terms of national health care reform in the USA, the results of Oregon have probably scared Congress away from any commitment to reform and its costs.

11.3 The Difficulties for Policy-Makers

The difficulties experienced by Oregon show that there is no technical fix to the problems of fair allocation of resources. Ranade (1994 p. 42) has posed four difficulties with which policy-makers must come to terms when considering allocation of resources:

1. What is a socially just basis for valuing states of health? Is the restoration of health to be valued more highly in the young than the old, the productive than the nonproductive or have all lives equal value?

2. Whose values count? Although the Oregon HSC made strenuous efforts to involve the public, two-thirds of those attending meetings were graduate educated professionals, and 60% of those were health care workers. The poor and sick were poorly represented.

3. What is the quality of information on 'benefit' which goes into the exercise? Doctors rarely agree on the 'best' form of treatment but their opinions are not based on good clinical evaluative research since 70% of treatments are still invalidated.

4. What is the ethical justification of barring access to treatments from which some individuals may benefit?
12. Conclusion

This chapter commenced with an outline of the theories of social justice. It is obvious that policy makers have not concerned themselves with the difficult task of acknowledging and clarifying their assumptions of these theories which underpin their policies. The Oregon experiment has, however, challenged policy-makers, economists and ethicists alike to examine the theories of social justice and the difficulties inherent in the allocation of health resources. There are many criticisms of Oregon's efforts, but none of the critics has provided any alternative method for the equitable allocation of resources in health care. The efforts of those involved in this experiment should be commended for trying to provide an efficient and equitable method for rationing health care services. While policy remains focused on the economics of health care provision, i.e. efficiency and the major strategy of cost reduction, equity issues remain sidelined. As discussed above, the topic of equity in health care provision is complex and difficult, both philosophically and practically, but it must be tackled by policy makers. Until policy makers consciously define a values framework to work to, issues of social justice will be overwhelmed by the economic imperative.
Chapter 6. ISSUES in CLINICAL PRACTICE

"I swear by Apollo Physician, Asklepios, Hygiea, Panacea and all the gods and goddesses, making them my witnesses ... Into whatever houses I may enter, I will come for the benefit of the sick."

Hippocratic Oath, circa 400 BC

1 Introduction

In the golden age of medicine, between 1920 and the 1970s, clinicians were highly regarded professionals and were responsible in many ways for the distribution of health care services according to societal values. Many impoverished patients were treated without charge, and others paid the doctor according to their circumstances, with richer patients subsidising the poorer. The downside to this situation was the paternalism of the medical model of accountability, challenged in the 1990s by the rise of consumerism and commercialism, the latter notably in the form of managed care.

Ever since the mythic Asklepios, focus of Greek and Roman medical tradition from approximately 1500 BC to 500 AD, Western culture has made demands of integrity, sacrifice and compassion from its physician healers, carried down to today's role of modern physicians and their obligations to care for the under-served. Patients still want their providers of health care to have a caring attitude and many physicians still attract a god-like status, although criticised for it. As Bailey (1996) points out, health care reform and economic pressures have revived ancient debates over the obligations of physicians and society to provide health care to the medically disadvantaged.

"Medicine is, at its centre, a moral enterprise grounded in a covenant of trust. This covenant obliges physicians to be competent and to use their competence in the patient's best interests. Physicians, therefore, are both intellectually and morally
obliged to act as advocates for the sick wherever their welfare is threatened and for their health at all times. Today this covenant of trust is significantly threatened.” (Cassel 1996)

This chapter looks at issues at the micro-level from the perspective of clinical providers. In terms of the structural model (Diagram 1), the chapter is concerned with Boxes 4 (issues) and 7 (problems).

2 The Physician-Patient Relationship

The physician-patient relationship is the keystone in medical care. Virtues required of medical practitioners include fiduciary responsibility, humility, honesty, intellectual integrity, compassion and effacement of excessive self-interest. (Crawshaw et al 1995)

Naturally not all practitioners, being merely human, will exhibit all virtues at all times! Health care system reforms are altering the physician-patient relationship by lessening clinical autonomy and interposing bureaucratic decision-making, processes and procedures. Any health care reform which reorganises services and affects the physician-patient relationship

“deserves more than an afterthought, since the interaction between patient and physician is the final common pathway through which reforms will be played out. In the short term, the success or failure of any new model [of managed care] will undoubtedly be judged primarily by its economic consequences. But the ultimate stability of the model will also hinge on the quality of the patient-physician relationships that emerge in the longer term.” (Emanuel & Brett 1993)

The foundation of the patient-physician relationship is the trust that physicians are dedicated first and foremost to serving the needs of their patients. In the Oath of Hippocrates, trust is a central element in almost all the ethical obligations of physicians. Patients expect a doctor to come to their aid, even if it means putting the doctor’s own well-being at risk, and trust that doctors will do everything in their power to help them.
It is this trust which enables patients to give confidential information and to place their health, their bodies and their lives in the hands of the medical profession. No other provider in the health care system is in a position to assume this kind of responsibility. Doctors care for their patients on a one-to-one basis, and are in the best position to know their patients' interests and can advocate within the health care system for their patients' needs.

"Without the commitment that physicians place patients' interests first and act as agents for their patients alone, there is no assurance that the patient's health and well-being will be protected." (American Medical Association. Council on Ethical and Judicial Affairs, 1995, p.331)

From the medical provider's point of view, perhaps the most crucial concern about health care reforms is the maintenance of the physician-patient relationship. Patients need to know that health care reform will not change their doctor's obligation to their individual interests and will recommend treatments consistent with good quality care, being only marginally concerned about cost. Health care reforms must be carefully analysed to identify the damage which may result from any solution which produces conflict in loyalties in the physician-patient relationship, and which may lessen the trust inherent in the physician-patient covenant. The covenant of trust is being threatened by reforms which could degrade the fundamental values of the medical profession and distort the physician's responsibility. Emanuel & Dubler (1995) propose an idealised concept of the patient-physician relationship summarised as the 6 'Cs': choice (of physician and practice setting); competence; communication; compassion (and caring); continuity of care; and (no) conflict of interest.
"The patient-physician relationship is the cornerstone for achieving, maintaining and improving health. The financing of the health care system and the regulation of its provision should be designed to foster and support an ideal relationship between the physician and patient." (Emanuel & Dubler 1995, p.328)

2.1 Models of the Physician-Patient Relationship

Emanuel & Emanuel (1992) outline four Weberian ideal-type models of the physician-patient relationship, which emphasise the different perspectives of:

1. The goals of the patient-physician interaction
2. The physician's obligations
3. The role of patient values
4. The concept of patient autonomy (see Table 11 below)

a) The Paternalistic Model

This model is also called the parental or priestly model, where the doctor acts as the patient's guardian, and does what is best for the patient with limited input from the patient. The conception of patient autonomy is patient assent, either at the time or later, to the doctor's determination as to what is best.

b) The Informative Model

This model is also known as the scientific, engineering or consumer model, which assumes clear distinctions between facts and values. The patient's values dominate, leaving the physician to supply the facts to the patient to enable the patient to select their preference. This model gives the patient the control over the process, with the doctor perhaps being relegated to a technical expert.
<table>
<thead>
<tr>
<th></th>
<th>Informatiave</th>
<th>Interpretive</th>
<th>Deliberative</th>
<th>Paternalistic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Values</strong></td>
<td>Defined, fixed, known to patient</td>
<td>Inchoate, conflicting requires elucidation</td>
<td>Open to development &amp; revision through moral discussion</td>
<td>Objective and shared by physician &amp; patient</td>
</tr>
<tr>
<td><strong>Physician’s obligation</strong></td>
<td>Providing relevant factual information &amp; implementing patient’s selected intervention</td>
<td>Elucidating &amp; interpreting relevant patient values as well as informing the patient and implementing the patient’s selected intervention</td>
<td>Articulating &amp; persuading the patient of the most admirable values as well as informing the patient and implementing the patient’s selected intervention</td>
<td>Promoting the patient’s well-being independent of the patient’s current preferences</td>
</tr>
<tr>
<td><strong>Conception of patient’s autonomy</strong></td>
<td>Choice of, control over, medical care</td>
<td>Self-understanding relevant to medical care</td>
<td>Moral self-development relevant to medical care</td>
<td>Assenting to objective values</td>
</tr>
<tr>
<td><strong>Conception of physician’s role</strong></td>
<td>Competent technical expert</td>
<td>Counsellor or adviser</td>
<td>Friend or teacher</td>
<td>Guardian</td>
</tr>
</tbody>
</table>

Source: Emanuel & Emanuel 1992, p.2222

c) The Interpretive Model

In this model, the doctor interprets the patient’s values and helps them to select interventions which realise these values. The doctor may often need to help the patient elucidate their values, as a counsellor, in a process of joint understanding.

d) The Deliberative Model

The physician-patient interaction in this model is to help the patient determine and choose the best health-related values which can be realised in the clinical situation. The
doctor acts as a friend or teacher, engaging the patient in a dialogue to discover the best course of action. The concept of patient autonomy is moral self-development and therefore empowerment.

Table 11 compares the four models in terms of the four variables noted above. Each model allows a role for patient autonomy, the concept of which has been mooted for the last two decades, with calls for greater patient autonomy or 'patient sovereignty'. As with all models, these are clearly ideal types, and in reality the doctor-patient interaction has different parts of more than one model in operation at the one time and may vary within a single relationship.

2.2 **Patient Autonomy and Clinical Autonomy.**

A major ethical value relevant to health care resource allocation is that of autonomy, which is the patient's right to control, as far as is feasible, their health care and treatment. This means giving patients the information which will provide them with opportunities for choice, including the option to refuse treatment. There is also practitioner autonomy to consider: clinical decisions ought to remain in the medical arena, not the financial management arena, but clinicians must be made aware of the system costs which they are generating with the tests and treatments they order. Leeder (1992) cites Jensen & Mooney's analysis of the ethic of autonomy, which they regard as one of the key dynamics of the conflicts between different values. They posit three varieties of autonomy within medical and health care:

1. **Informed consent.** This form of autonomy has patients being informed of treatment options, and then making their own decisions. The problem of how to
transfer from clinician to patient the knowledge required to make an informed decision presents as insurmountable. Clinical decisions are complex results of an amalgam of knowledge, experience, intuition and skills. The expectation that medically unqualified patients will be able to accept the responsibility for making the treatment decision is unrealistic except in the most simple of cases. Some patient advocates see this argument as wanting to leave “medical paternalism and jealously guarded ownership of knowledge and technology firmly in place”. There is, however, a great deal of difference between old-style medical paternalism and the current doctor-patient relationship entailing joint decision-making.

2. Medical care as a market good. This form of autonomy allows individual values to dominate with all values being regarded as relative. Patients may choose to spend their money on health care or other goods as they see fit. There is no attempt made to preserve or enhance the health of the community. This form does not address the problem of inadequate personal resources to purchase health care. This concept relates mainly to the USA, although elements of it have crept into UK and NZ systems with the focus on competition in internal markets.

3. The community decides to care for its weak members. This form leads to solidarity and possibly accounts for movements such as the World Health Organisation's Health for all by the year 2000 movement. This may well lead to another form of paternalism, this time presided over by the public health professionals. Indeed, there is evidence of governments shifting moral responsibility onto individuals for their health or ill-health, in what The Lancet terms ‘coercive healthism’.
"Each decision taken by our moral health guardians (public health bureaucrats), deserves the public's most critical scrutiny. Otherwise, we risk losing control over our moral choices about health to the prejudices of governments who, in the nefarious climate in which politics is conducted, may wish to disguise their lack of interest in the public's health by shifting responsibility over to the individual." (Editorial, The Lancet; 1996; 347:1197)

2.3 Finding a Balance

There is a need to find a balance between the paternalistic model, where clinical autonomy allows no patient autonomy, and the informative model where the doctor loses control over the medical decision-making to the patient. The paternalistic model is no longer tenable, except in certain medical emergencies, and there has been a shift towards the informative model, with business terminology employed to describe doctors as 'health care providers' and patients as 'consumers'. The proliferation of patients' rights statements, the consumer movement and the judgments of courts where cases dealing with 'living wills' which document the wishes of patients to end their own lives or to refuse treatments and life-sustaining procedures, have all emphasised the dichotomy of physician-patient autonomy. Current informed consent standards are patient-oriented, replacing older physician-based ideals, and give further endorsement to the informative model. Doctors now have a duty to provide relevant facts to empower their patients to use their own values in their selection of preferred treatment.

There is the danger of litigation and damages costs against doctors who do not fully inform their patients, as Rogers v. Whitacker (see MJA 18 April 1994; 160:528) and other court cases attest. But the reality of the doctor-patient interaction includes a 'caring' component, which, when present, negates the informative model, which presupposes that doctors - highly trained and experienced - would allow patients -
usually ill-informed - to counterdict medical decision-making. Objections to the deliberative model include the idea that patients see their doctor for health care problems, not to engage in philosophical discussion on morality and values. This model in practice may move towards paternalism, also, because any practitioner acting as a friend of teacher would try to persuade a patient away from a (medically) unwise decision.

Clearly, elements of the four models may be in evidence in any given interaction, and the balance between physician and patient autonomy will shift according to the circumstances. However, the dominance of the informative model in bioethics, consumerism and legal standards is of concern, as its concept of patient autonomy as the patient having choice of and control over medical care is seriously flawed. Any model which precludes caring from the interaction, and the relegation of the doctor to a competent technical expert, is contrary to 3000 years of believing healing to be much more than a technical exercise. The prominence of the informative model is aiding and abetting health care reforms which emphasise technical efficiencies over equity, and business concerns over health concerns.

2.4 Clinicians and the Allocation of Resources

The question here is: at what point should consideration of costs enter the clinical picture? Should the postulate of medical care be: each doctor will do his/her best for each patient, in the light of their own clinical knowledge and judgment, with the resources available to him/her? (Office of Health Economics, UK, 1979, p.274) In the UK, clinicians in both hospital and general practice are aware, probably to a far
greater degree than anywhere else, of their responsibilities towards the greater society, not just their obligations to their own patients. They must make the limited health care resources within the NHS meet all the justifiable health care needs of their collective patients. Under managed care in the USA, however, clinicians are becoming more aware of the need to spread finite resources amongst the organisation's patient population. Hence national health care systems (and managed care entities which may be viewed as mini-national health systems) are often viewed as producing implicit rationing because centrally-funded health care costs prevent people from having everything which may be of benefit to them. In the USA in other than managed care situations, there is a very definite division between public and private patients, with the latter being permitted anything available if they can pay for it. For public patients, however, the American Medical Association has long held that the individual physician and the medical profession as a group must be concerned with maintaining a proper balance between adequate medical care for the welfare patient and economical use of public funds. (Editorial Annals of Internal Medicine 1996; 124(6): 605-6. See also Daniels 1986; Miller & Miller 1986) The individual clinician, as the key person in the care of the welfare patient, must, therefore, take into consideration not only the medical but the financial aspects of various acceptable modes of treatment.

In Australia, Canada and New Zealand, the methods of financing the various sectors have caused implicit rationing. Hospital infrastructures have been allowed to deteriorate, so that equipment is not available, or operating-theatre times are restricted, thus preventing efficient management of resources. Clinicians must make decisions all
the time as to which patients will have treatment and which will not, who will be returned to main wards early from intensive care units to free a bed for the use of a more critically ill patient. This may be seen as efficient use of resources by some; by others it will be seen as the deterioration in the quality of care. In these countries, however, the clinicians in the hospital sectors must consider the wider picture, encompassing much more than the requirements of their own patients. In the ambulatory care sector, (i.e. GPs, family medicine practitioners), there is more latitude for clinicians to put their patients' needs first, but government control over fee schedules and remuneration systems dictate a pragmatic attitude toward keeping one eye on the financial side of medical care provision. This is not to say that clinicians will be easily won over to the rationing role envisioned for them by governments, and the role of ethics in health care provision will be invoked by both sides as evidence of the validity of each side's argument. The following quote is an example of the position taken by many clinicians in the USA, and those in Australia who are aware of the ramifications of the concept of 'managed care':

"This [the doctor/patient relationship] will be the greatest challenge to the role of ethics in the health care reform debate. If parties other than the physician and patient determine what treatment is necessary and appropriate for an individual patient, the therapeutic relationship will be so severely eroded as to render it meaningless and ineffective. This does not mean that physician practices cannot or should not be monitored or that issues of cost are irrelevant, but it highlights the importance of taking decisions about rationing and the appropriateness of care out of the consultation room and away from the bedside and bringing these debates to the level of the conference table and the community. Ethics is critical in framing the health care reform debate and in monitoring the outcome of the process. Although the present debate [in the USA] mainly focuses on pragmatic concerns in politics and economics, the proposed solutions will be acceptable only if the values reflected in the choices are reasonable and defensible." (Fleischman 1994, p10,11)
Williams (1992), chief protagonist for the use of QALYs in the allocation of health care resources, takes issue with clinicians who argue that practising medicine with an eye on costs rather than purely medical considerations means placing themselves on the slippery slope of compromised ethics. Williams argues that, on the contrary, it cannot be ethical to ignore the adverse consequences upon others of the decision you make, which is what 'costs' represent. To an economist 'what will it cost?' means 'what will have to be sacrificed?' and not necessarily 'how much money will we have to part with?' This issue represents the tension between the medical ethic of clinical autonomy and the basic ethical requirement of considering justice in health care resource allocation. In other words, the needs of the individual patient versus societal requirements to share finite resources. The tension is exacerbated in those areas where health service management is involved in the decision-making process, such as in managed care institutions, where cost is an important factor. Williams' position is clearly put:

"...since issues of community-wide 'just dealing' between patients will go beyond the scope of any one doctor's realm of action, it could be argued that if the judgments made by a particular doctor (exercising his clinical freedom) clash with those of someone with authority from the community to allocate scarce resources across rival claimants, the clinical freedom of the doctor has the weaker moral claim, and can legitimately be constrained accordingly." (Williams 1992)

Cochrane argued in the 1970s that if all unnecessary treatment could be eliminated, the resources already available for medical care would probably be sufficient to meet proven needs. There is often little or no scientific evidence that a particular treatment will benefit a patient, but the doctor does not want to leave undone anything which may provide the slightest benefit. (Cochrane 1972) But eliminating unnecessary treatments
requires that clinicians know which treatments work and which don't, and that they have the ability to persuade their patients that 'doing nothing' is the best option. It also requires that patients have an understanding of how the health care system works, and how much treatments cost, and the fact that resources used for them are then unavailable for patients who may be in more urgent (medical) need. This knowledge of efficacious treatment either does not yet exist, or if it does, its dissemination is very limited. It also presupposes that patients will put aside self interest - not very probable given the attention being paid to consumer groups and the publication of Patients' Charters, and the public perception that clinicians make every effort to maximise their incomes. Consumerism is thus another issue which is affecting clinical practice, and this concern could be located in Box 1 of the Structural Diagram, dealing with values, the market system, public opinion and the individual versus the community. For present purposes, let it be said that consumerism has given rise to the demand for more patient involvement in their own treatments, placing patient choice and patient empowerment on the agenda for health care policy makers.

At the clinical level, at the one-to-one physician-patient interaction, however, it is important that all stakeholders - politicians, managers, doctors and patients - realise that patient satisfaction does not mean instant patient gratification.

"Indeed, it may mean patients' instant displeasure when they are denied their fanciful expectations at the hands of a more critical and scientific medical profession." (Pickering 1996, p.380)

Where fee for service is operating as the means of clinician remuneration, such an attitude may cause financial ramifications to the practice. Potential for conflict of
interest between patient benefit and clinician benefit must be uppermost in practitioners' minds.

3. Conflict of Interest

The rise of consumerism and the introduction of business principles to the provision of health care has renewed interest in the problem of conflict of interest in medicine, a phenomenon which began to receive serious attention in the medical literature in the 1980s. (Thompson 1993) A conflict of interest is described as a set of conditions in which professional judgment concerning a primary interest, e.g. a patient's welfare, tends to be unduly influenced by a secondary interest, such as financial gain. The secondary interest in itself may be legitimate, even desirable, but in conjunction with the primary interest in the context of a professional judgment, it must be of lesser import. The growing role of governments in regulating for conflict of interest can lead to uniformity and procedural complexity in the legal process, which creates more difficulties when trying to fit the rules to the specific situation. Financial incentives for the inappropriate utilization of care have usually been constrained by a mix of widely held ethical views. Medical ethics placed patient welfare before profit-making in all circumstance, and the provision of non-profit organisations was thought to prevent the abuse of patient care for financial reasons. However, with the advent of competition within health care, including managed care, which requires providers to consider the costs of alternative protocols of care, the clinician is no longer the independent decision-maker guided solely by a professional code, a paradigm that has dominated theories of medical ethics. (Swartz & Brennan 1996) In the new competitive
environment, the primary interest (patient's welfare) is in danger of a secondary interest (e.g. paying less for a service) taking precedence, in, for example, the case of fund-holding GPs. Other areas of conflict of interest include referrals, ownership, gifts, etc.

"We expect that a physician's primary concern will be his or her patients' well-being, even though physicians may have obligations that conflict. Attending to the well-being of one patient may conflict with caring for another patient. Similarly, it is well recognised that caring for a patient may conflict with - and even be superseded by - the need to protect the interests of a third party. [e.g. the partner of an HIV+ patient] Nevertheless we do expect that the physician's care of a patient and concern for the patient's well-being will take precedence over the physician's own personal interests, especially financial interests. This means in a fee-for-service environment, physicians should not order procedures merely for their personal financial enrichment. Conversely, in a capitated system, physicians should not withhold appropriate medical services to increase their own financial rewards. These expectations inform the rules restricting conflict of interest.". (Emanuel & Dubler 1995, p.325)

Government regulations for health care provision which force medical professionals into situations of conflict between their patients' well-being and their own financial viability need to be identified and discussed. This situation may arise when government remuneration schedules are too low, forcing practitioners to raise the number of patients attended and spending less time with each, as in the case of Australia's Medicare system. If a medical practice becomes unviable, a practitioner has no choice other than to increase the practice load, or raise the price of consultations beyond existing levels (i.e. increasing the 'gap' payment paid by the patient), or leave medical practice.

4. Appropriateness of Care

Medical practice is confronted with considerably more uncertainty than is generally imagined. It has been demonstrated that four-fifths of medical procedures and two-
thirds of medical goods have never been evaluated with respect to their effectiveness or cost. Only about 15% of medical interventions are supported by solid scientific evidence, partly because only 1% of the articles in medical journals are scientifically sound, and partly because many treatments have never been assessed at all. (Smith 1991) Maynard & Bloor (1995, p.177) assert that only about 10% of interventions have some basis in cost effectiveness. Some of the ramifications of this situation are that

i) health care system reform ought perhaps to be concentrating at the micro-level, to ensure that resources are available to research the efficacy of interventions with RCTs; and/or

ii) tighter regulations are required to ensure that medical goods, including new technologies, are investigated prior to dissemination in the market place. A candidate for tighter regulation is the pharmaceutical industry which regularly markets the same product under more than one label with differing prices. Generic pharmaceutical products are likely to become the standard for pharmaceutical benefit lists, as they are almost always cheaper than the more expensive ‘boutique’ products; and/or

iii) publishers of scientific and medical information need to establish rigorous peer review or evaluative mechanisms to try to stop the avalanche of ‘scientific’ papers of dubious worth.

The fact is that much of the resources for health care provision are simply wasted. Some of the system reforms, notably in the UK, have increased this wastefulness with bloated administrations. Even where interventions have been thoroughly investigated,
they may be inappropriately used, so that in many cases they may provide only very marginal benefits to health outcomes. (Weisbrod 1991) OECD countries are increasingly assessing new technologies, but the level of commitment remains inadequate. (OECD 1994b, p.26) [See also Health Policy volume 30 (1-3), an issue devoted to health care technology]

Medical practice patterns vary widely across and within countries, even after allowing for confounding variables such as age, morbidity or systems of funding and health care delivery. (Westert et al 1993) In the USA, large differences in procedures and utilisation rates among regions, hospitals and physicians cannot be attributed to differences in patient needs. (Wennberg 1987). Other countries also exhibit variance in treatments and usage, differences which exist even after controlling for the severity of illness factor. Such variations raise questions about whether they reflect unnecessary costs in high-use areas or less-than-optimal care in low-use areas. (Epstein 1990) Within pharmaceutical usage data, prescribing rates vary enormously across countries: average numbers of medicines prescribed vary by as much as 4 or 5 times (OECD 1993e in OECD 1994b, p.26) When prevalence of alternative medicine consultations and over-the-counter drug usage is taken into account, the issue of appropriateness of care takes on greater importance. MacLennan, Wilson & Taylor (1996) found that in Australia, the extent of the use of alternative therapists and medicines establishes that it is a major industry and raises questions about its place in health care delivery. Over-the-counter drugs usage in the UK equates to one third of the total NHS drugs bill. (Blenkinsopp & Bradley 1996)
Cross-country variation has arisen from both demand and supply factors - individual countries may have different preferences in the degree of 'caring' as opposed to cure, in the range of services to be provided or covered by state insurance, and in the way services are delivered. While these preferences may have been culturally ingrained and may be difficult to change, there is no reason why they should be excluded from the process of reform. The key consideration for policy in this context should be the impact the reforms have on system effectiveness and health outcomes, while minimising costs of provision.

4.1 Impact of Technology

The advances in technology have also acted as a pressure on the physician-patient relationship, especially where consumerism has spread the gospel regarding the life-saving, life-prolonging properties of new developments. Clinicians can be pressured into referring patients for diagnostic or treatment procedures, which may raise questions of conflict of interest and appropriateness of care. Technological change is broadly defined to include techniques, drugs, equipment and procedures used in providing health care. The capacity to treat both illness and disabling conditions has grown in many important respects: procedures such as improved cataract operations, renal dialysis, organ transplants, coronary bypass, hip and knee replacements and micro-surgery have increased the range of conditions which can be successfully treated. Advances in anaesthetics have reduced the risks of operating on older people, new imaging and other technology (echography, improved radiology, magnetic resonance scanners, endoscopy and biological tests) have improved the capacity of diagnosis.
There are also continuous, important advances in pharmacology. Central to the current health policy debate are questions about the social costs of new technologies and how their introduction should best be regulated. (Banta 1994; Selby Smith, Hailey & Drummond 1994) There are the ethical issues raised by new possibilities in medical treatments, and access to and rationing of new services, all of which have ethical, political and cultural dimensions. New technology often deals with the incapacitating after-effects of disease, e.g. transplants and artificial organs, treatment of cancer or palliative medicine which limit the symptoms of disease. Policy-makers need to be aware of the net effect of new technologies and their implementation on the health of individuals and populations. The progress of technological solutions to health problems is often cited as one of the major reasons for the escalation of health care costs. (Battista et al 1994; Loewy 1994) Technological break-throughs often concern new methods which are much cheaper than current methods; while a one-to-one comparison can therefore be made, resulting in lower costs, the volume of usage of the new cheaper method is usually far greater, hence total costs increase. Overall costs have increased in some areas. Between 1972 and 1982, the cost of treatment for heart attacks increased by a factor of 3 because of new techniques such as cardiac imaging, angiography and coronary bypass graft surgery. (Weisbrod 1991 cited in OECD 1994b, p.13)

Policy-makers must keep in mind, however, the fact that, over time, the new technologies of today become tomorrow's palliative care. Policies can be made to ensure that adequate evaluation of technological innovations is carried out, and that
new technological machinery is available on a population-needs basis only, so that proliferation of under-utilised technology cannot cause supplier-induced demand for health care.

"Deployment of medical technology must rest on rigorous and continuous assessments of effectiveness, cost and safety, and the appropriate selection of patients who can benefit." (Ranade 1994, p.39)

Assessing the role of technology is, however, complex. Some innovations have been cost-saving: drugs reducing the need for surgery; vaccines reducing the incidence of infectious diseases and antibiotics reducing the potential for opportunistic bacteria in patients weakened by other disease states. Much of the impact has increased health care costs, but these higher costs may have been balanced, to a large extent, by positive effects on outcomes. The market plays a relatively small role in assessing the value of technology. Few questions are asked as to the effectiveness and appropriateness of new technology or how this should be balanced against costs. In competitive health care provision, new technologies are marketed to entice new customers. Loewy (1994, p101) suggests that when competition and the market are used to ‘regulate’ health care, such as in the USA, then technology - instead of being used to benefit patients - is apt to be used primarily to maximise individual profit.

"It becomes a weapon between what is often painted as ‘warfare’ among health care providers and institutions."

On the other hand, in Australia the introduction and diffusion of health care technologies is determined by market forces and regulation, and there have been significant successes in informing policy through appropriately targeted and well-timed assessments of various new technologies. (Hailey 1994)
New technology has been included in the risks covered by insurers, although the rate of diffusion differs from country to country. With the cost of using technology covered, the marginal cost to the patient has been low and doctors have been inclined or felt morally obliged to prescribe or use new treatments as long as some marginal benefit to the patient could be expected. (OECD 1994b)

"Experience suggests that control of health technologies can only be fully effective when there is some measure of central control on funding, distribution and application." (Hailey & Roseman 1990)

The attention of reformers has turned in the last decade to the measurement of how effectively health care systems are working, and outcomes measurement has become the latest health research topic. This encompasses the evaluation of treatments, patient satisfaction, and the movement towards the practice of evidence-based medicine.

5 Outcomes Measurement

There are two types of 'outcomes' in health care. One concerns epidemiological outcomes for the population as a whole, and research in this area gives the gross results of health status in terms of morbidity and mortality rates and associated data. Statistical techniques are used to obtain epidemiological information. The other type is at an individual patient level, where the results of treatment(s) are given in terms of whether the patient is cured or the degree of relief obtained, the level of disabilities experienced and the quality of life expected. Research for this type of outcome relies on clinical trials to find which treatments work and which don't: some treatments may actually harm the patient. It is the knowledge gained by individual practitioners in working with their patients which allows them to weigh up the risks and benefits associated with
particular treatments as applied to each patient. Each clinical situation is therefore unique to varying degrees, and this point must be remembered when discussing the validity of clinical trial meta-analysis. (Egger & Davey Smith 1995; Hasselblad 1995; Villar, Carrolli & Belizan 1995; Delahaye 1991; Sacks 1987)

The outcomes of health care systems are inherently qualitative end results, but the instruments used to measure these outcomes are often of a more quantitative nature. (see Brown, McCartney & Bell 1995, p.193 for 10 such instruments) In addition to this problem, the choice of instrument is dictated by what it is to be measured, and they can be classified into three main types:

i) those which evaluate the effects of interventions on individual service users, e.g. functional status measures or activities of daily living;

ii) those which compare aggregated results for different treatments or units, e.g. multi-dimensional health status profiles or indices;

iii) those which inform macro-resource allocation, e.g. measures of mortality, morbidity.

Measuring outcomes, therefore, is not only a major conceptual and practical problem, but of vital concern for health care reform which aims to have clinicians use the most cost-effective treatments while at the same time ensuring quality of care. Relman (1988) has called the outcomes movement ‘the third revolution in medical care’, consisting of assessment of outcomes, analysis of effectiveness and quality assurance. Ellwood (1988) suggested a major initiative of ‘outcomes management’, whereby
clinical guidelines and standards would be based systematically on patient outcomes.

But Tannenbaum (1994) cautions that the recent ascendency of outcomes research

"is as much political as scientific, empowering the research community relative to practicing physicians, lending medical legitimacy to payer-promulgated practice guidelines, and creating additional clinical work around a false standard of medical certainty."

There are two ways of viewing the concept of outcomes measurement. One view is that statistical analysis of treatments and results can be used to provide a scientific basis for decisions on what works and what doesn't work in medical practice. Information may come from clinical trials (Herxheimer 1991; Kassirer 1992; Sacks et al 1987), or the analysis of medical records (see Anderson 1994). This data can then be used with cost data to provide cost-benefit analyses. (Gerard 1992; Johannesson & Jonsson 1991; Richardson & Cook 1992; Weinstein & Stason 1977) The other view is that clinical decisions should be made on individual clinical reasoning about individual patients on the basis of personal experience and theories of cause and effect as well as on the basis of statistical knowledge. (Tannenbaum 1993)

There are dangers in attempting to make an outcome measure an object of policy, as correlation between an outcome measure and the health service being measured can be meaningless. This is even more likely if the outcome measure is a proxy for some other aspect which cannot be measured directly. To give an example, if it is considered that there is a correlation between short waiting lists and 'quality of service' - as the UK NHS is doing - it is almost certain that the outcome measure will be implemented in such a way that the evaluation of it will show the desired result. If such a correlation is assumed, then the length of the waiting list will become an
outcome measure. Weight is then placed on shortening the waiting lists, which can easily be done by lengthening the time between the GP’s referral and the appointment to see the specialist. Time spent waiting to see a consultant is not, as the outcome measure is defined, time on a waiting list. While this procedure will then shorten the waiting list, showing a success in terms of the outcome measure, the correlation between time on a waiting list and quality of service no longer exists. Meanwhile, the patient has not been attended to any earlier, but politicians can legitimately say that waiting lists are shorter, inferring that their policies are working well.

Faced with such difficulties, decision-makers often opt for simplistic rules-of-thumb which can have unforeseen and possibly damaging consequences. The recent NHS Patient Charter promised patients who needed non-urgent treatment that they would not have to wait more than two years. But the blanket limit of two years had no rational basis, being merely an arbitrary diktat of a minister, who thought two years sounded politically feasible. The imposition of this two year waiting limit, however, forced managers into making resource allocation decisions for which there is no clinical rationale or mandate.

Research into outcomes and their measurement is time consuming and costly, but without it, the trade-off between quality of care and efficiency will be made without adequate knowledge. As an editorial in the *BMJ* asserts: practice should be based on sound knowledge of which interventions make what difference.

"The basic premise of outcomes research is that when recommending treatment, doctors need to know what are the likely outcomes of different treatments and what matters to individual patients. Only systematic research can provide this information. Patient preference is crucial. ... Unless clinical decisions consider patients’ preferences, we run the risk of providing treatment to patients who do not
value the expected outcome while withholding it from those who do. There are other advantages of outcomes research in addition to those that help doctors and patients decide about individual treatment. Data on how people value alternative outcomes can inform policy decisions such as allocation of resources. Outcomes can be compared between providers and used to identify best practice and to develop practice guidelines. Such data can be used to distinguish appropriate and desirable variations in practice from those that are neither. And lastly, and perhaps most importantly, rigorous comparisons of outcomes across providers and processes of care allow the medical profession to update continuously its knowledge base, thereby providing a scientific basis for professional self assessment and improvement." (BMJ 1994; 308:1583)

From the USA comes a warning that, while outcomes research "provides a window on the performance of our health care system, ..... its ascendancy is a flight from the real inadequacies of health care." (Tannenbaum 1994)

5.1 Evaluation of Treatments

One of the most important methods for assessing whether treatments really do more harm than good is the randomised clinical trial (RCT), made famous by Bradford Hill half a century ago. Cochrane (1972 p.22), in crediting Bradford Hill with the critical step forward in bringing the experimental approach into clinical medicine, says

"he has been much honoured, but I doubt if we honour him enough. His ideas have only penetrated a small way into medicine, and they still have to revolutionise sociology, education and penology."

Cochrane believed, in 1972, that the problem of evaluation was the first priority of the UK's NHS, and further, that the tool for the job was the RCT.

"The main job of medical administrators is to make choices between alternatives. To enable them to make the correct choices, they must have accurate comparable data about the benefit and cost of the alternatives. These can really only be obtained by an adequately costed RCT." (Cochrane 1972, p.25)

This issue of evaluation continues to be of prime importance in the administration and management of health care systems. The rise of 'new public management' in health
care systems brings with it changes which will require direct involvement of clinical managers, so that the concept of the evaluation of medical interventions is not lost.

5.2 Randomised Controlled Clinical Trials (RCTs)

In clinical research, the scientific method is exemplified by the increasing prominence of the RCT and by the adoption of guidelines for the critical appraisal of evidence. The International Cochrane Collaboration, named after British epidemiologist Archie Cochrane mentioned above, was set up in September 1992 to systematically review, evaluate and publicise the available evidence from randomised controlled trials. The Collaboration has 8 centres around the world, including the Cochrane Centre in Adelaide, which is funded by the NH & MRC. Professor Chris Silagy, director of the Australasian Centre to which many Australian and New Zealand researchers are contributing, pointed out that while reviews of research had a critical role, their often poor quality meant that advice on some highly effective forms of health care was delayed for many years, and other forms of care were recommended long after controlled research showed them to be ineffective or harmful. (Australian Doctor, 18 November 1994, p.11.) Such expert reviews, as published in journals and textbooks, are a popular source of medical information, but unfortunately suffer from a number of well documented shortcomings which typify those hazards of retrospective research which meta-analysis strives to avoid. Comparisons of the results of meta-analysis and recommendations of traditional reviews reveal wide discrepancies between available evidence and published opinions. (Stockler & Coates 1993) The underlying assumption of the Collaboration is that health care interventions will be more effective.
if they are based on complete and up to date evidence instead of out of date research, anecdote and conjecture. Evidence-based medicine has been hailed as the new paradigm of clinical care, (Ahmed & Silagy 1995), but putting theory into practice will provide a huge challenge. For this concept to succeed, health care systems require an infrastructure for the dissemination of evidence-based medicine into clinical practice, with activities such as quality assurance, practice guidelines and managed care protocols.

5.3 Evidence-Based Medicine

"Evidence-based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients." (Emphasis added) (Sacket et al 1996)

Good medical practitioners in the Western tradition have always taken evidence of previous treatments into account, so the evidence-based medicine concept is not new. Practitioners have always integrated their own experiences with the clinical experience and research of others. Clinicians acquire clinical expertise - that is, proficiency and judgment - by this process. In this manner, older treatments are dropped and new techniques undertaken. However, the sheer volume of new information being generated is making it harder for clinicians to keep up with external clinical research, and more collaborative measures (e.g. Cochrane Centres) are required. What is new is the way in which non-medical policy-makers and bureaucrats have embraced the concept as a way in which to cut costs and curb clinical autonomy. The concept has the potential to lower uncertainty for these non-clinical decision-makers. Out of evidence-based medicine has come the logical consequences of guidelines, clinical
protocols and the threat of ‘cookbook’ (i.e. following a set routine for treatment) practice of medicine.

Non-medical personnel do not seem to recognise the fact that clinicians must decide for each individual patient whether the external clinical evidence is suitable to use in this specific context, therefore making ‘cookbook’ medicine untenable. Non-medical personnel are prone to argue that disease ‘X’ requires treatment ‘Y’, which is the conceptual basis underlying technical solutions such as diagnosis-related groupings (DRGs). Non-medical personnel must also recognise the fact that evidence-based medicine may actually increase costs and their surmise that this concept can be used for cost cutting is fallacious.

A debate about the appropriateness of evidence-based medicine is currently occupying researchers, and Shuchman (1996) records in The Lancet the opposing sides of the argument. Ralph Horwitz of Yale University considers that evidence-based medicine would be more appropriately termed ‘literature-based medicine’, and has castigated its proponents for seeing literature as being more important than clinical experience. On the other hand, David Sackett of Oxford University thinks that evidence-based medicine is doing more good than harm, and its problems stem more from communication than anything else. Evidence-based medicine, according to such proponents, is medicine as well as evidence, without which clinicians' knowledge and performance would deteriorate. There are, however, many who would argue that there are decided harmful consequences for patients. There are worries that medical training now emphasises the scientific literature over the doctor-patient interaction, and
concerns that the literature produced through the efforts of evidence-based medicine was being misused by policy-makers to create a dogmatic atmosphere in which practice guidelines had greater authority than physicians. Health ministers are calling for evidence-based medicine in the hope that clinicians will utilise only those interventions which have been proven effective. The medical profession has answered in kind, pointing out that the dangers for the community are substantially higher from uninformed policymaking, and cite the impact of poorly designed and untested mental health policy on mental health services. (Ham, Hunter & Robinson 1995)

In the commendable efforts to attain and disseminate information on the efficacy of treatments, and to attain value-for-money by discarding ineffective treatments, it is possible that the quality of medical care will suffer as an unintended consequence.

6 Quality of Care

Donabedian (1966, 1978, 1982) divides quality of care into components of structure, process and outcome. ‘Structure’ included the physical and organisational characteristics of the health care facility; ‘process’ was the treatment carried out and ‘outcome’ meant the result for the patient. Donabedian later (1992) expanded the critical concepts about quality to include attributes of effectiveness, efficiency, optimality, acceptability, legitimacy and equity. Maxwell (1984) used the six dimensions of effectiveness, acceptability, efficiency, access, equity and relevance. Other factors involved in quality of health care include those of accountability: clinical audit, institutional accreditation and individual re-accreditation. As Taylor (1996,
p.626) states, the use of such approaches can help promote valuable insights into the strengths and weaknesses of services,

"But complex intellectual analyses of 'quality' risk leaving many health care workers uncertain and worried that their working lives are being diverted towards the pursuit of a chimera called quality that has little to do with patient's real needs."

The concept of quality of care needs to be analysed in the clinical (micro-level), institutional (meso-level) and political (macro-level) arenas. Figure 9 shows the relationship between these levels. The test for quality of care will be the outcome of patient treatment (clinical), hospitalisation or programmatic intervention (institutional) and population health status (political) although the latter arena will contain many other factors besides quality of care. Medical treatment is not invariably followed by clinical improvement; in fact treatment sometimes causes other problems. To gauge quality of care outcomes, auditors need to know whether the patient benefited from the medical intervention or not; whether the intervention made the problem worse; or whether there was no change in the condition. It would be logical for those decision-makers interested in quality of care to ensure a constant review of therapies - especially surgical and pharmaceutical - with a view to making necessary adjustments to practice guidelines. It appears, however, that the process of treatment is more important than its outcome, especially where drug prescribing is concerned: enormous effort is devoted to the auditing of prescription numbers, whereas the actual efficacy of these prescribed drugs is not reported or analysed. (Pickering 1996, p.379) In the UK, the Audit Commission found in 1994 that between 50% and 70% of GP consultations result in a prescription being written. Add to that the self-medications and the over-
the-counter (non-prescription) drugs, which in 1994 in the UK reached 1,268.5 million pounds sterling, approximately one third of the NHS drugs bill of 3.6 billion pounds sterling. (Blenkinsopp & Bradley 1996) The efficacy of these medications is not monitored: which of them work, which don't and which cause iatrogenic problems has not been analysed. There is scope here to improve quality of care.

**Figure 9**
**Levels of Health Care Qualities**

| **SYSTEM QUALITY** | Population-based care: Political Level  
Health outcomes and service quality considered across all dimensions and agencies. Complex trade-offs often required. Traditional focus of managers in health authorities and health policy-makers.  
**Information** | Hospital care: Institutional Level  
Service standards and user/purchaser satisfaction considered in relation to the requirements of clients served/selected. Regulation of processes and costs often central activities. Natural focus of market oriented provider managers.  
**INSTITUTIONAL QUALITY** | Individual Care: Clinical Level  
Access and effectiveness dominant considerations, together with relief of immediate distress. Frequently the main focus of professional concerns about quality  
**EPISODIC QUALITY** |

Surgical interventions are often performed because a procedure is fashionable. As Pickering (1996, p.380) points out, if tonsillectomies had been medically necessary instead of the fashion, they would still be performed by the thousands every week, and they are not. While a medically unnecessary tonsillectomy may not cause undue harm to the patient, it is a waste of resources. Medically unnecessary radiology, on the other hand, when used as a diagnostic tool in an effort to leave no stone unturned in the quest for accurate diagnosis, may well cause harm.

Alternative health services is a growth area allied to self-medication with 'health food' drugs from 'natural' products. Australian researchers (MacLennan et al 1996) conducted a representative population survey of persons aged 15 years or older living in South Australia, and assessed the rates of and types of alternative medicine and therapists used by this population in 1993. In their extrapolation of the costs to the Australian population, in 1993 A$621 million was spent on alternative medicines and A$309 million on alternative therapists. This compares to the A$360 million of patient contributions for all classes of pharmaceutical drugs purchased in Australia in 1992/93. As the authors state, the public health and economic ramifications of these huge costs are questioned in view of the paucity of sound safety and efficacy data for many of the therapies and products of the alternative medicine industry. It is also instructive to ponder on the fact that so many citizens are willing to spend from their own pockets for alternative medicine, yet begrudge paying medically-qualified clinicians anything over and above the Australian Medicare rebate.
6.1 An Alphabet Soup of Technical Solutions

The renewed focus on the notion of quality in health care is to be found in the literature under various terms: ‘quality assurance’ or ‘quality assessment’ (QA), ‘quality development’, ‘continuous quality improvement’ (CQI) or ‘total quality management’ (TQM). The focus is actually on the sensitivity of providers to their customers' satisfaction, and it is questionable as to whether this is entirely appropriate in health care provision. The terminology and basic underlying concepts stem from the industrial sector and the 1960s [see Deming 1986], and the move towards competition within health care systems together with the rise of the consumer movement has given impetus to the QA/TQM movement. TQM as a philosophy focussed on systems and appeared to have the potential to reconcile cost/quality conflicts and improve economic efficiencies overall by improving operational performance (and financial performance in the case of for-profit institutions). There is, however, little credible evidence that TQM programs produce overall benefit to health care organisations especially in cases where physicians have not participated in the process. (Eskildson 1996, Arndt & Bigelow 1995; Bigalow & Arndt 1995) According to Taylor (1996, p.628), critics of health care quality management have questioned the evidence of the effectiveness of the techniques used, and also the extent to which patients have benefited from the expenditures on various forms of audit, service standard setting, data monitoring and other initiatives, which have totalled in excess of one billion pounds sterling in the UK since the beginning of the 1990s.
Two assumptions inherent in TQM may not translate to the hospital environment:

1) hierarchical management control over the technical care; and

2) the dominance of rational decision-making.

The two assumptions need to be taken into account when applying TQM to hospitals, otherwise they may compromise success. (Smith 1995) In the USA, where TQM is seen as a technical fix to serious problems caused by efforts to continue the provision of the same quantity of high quality health care services with fewer resources, researchers will need to find a causal relationship between patients' judgment of quality and financial performance. Not the least of researchers' problems will be the availability of legitimate performance measures, and acceptance of them by all stakeholders. Some stakeholders don't appear to need research results, as Smith (1995) reports:

"From personal observations and discussions with hospital system CEOs engaged in CQI, I am convinced that the benefits are so apparent to them that much of the documentation is considered superfluous. ... Perhaps, as more practitioners of CQI share their convictions, and as organisational theorists present their theoretical propositions in the academic literature, researchers will work with organisations to measure performance impact on bottom-line benefits."

6.2 Clinical Level

At the micro-level, the introduction of medical practice guidelines have undermined clinical autonomy and may have the opposite effect to the desired aim of better practice. The definition of quality of care can be difficult to create and even more difficult to put into practice. What may seem to some as practical quality of care may be judged by others to be examples of overservicing. Practitioners trying to provide quality care can be accused of practising defensive medicine, and patients who think that they are not receiving the highest of care may decide to sue their medical
practitioner. Questions of perverse incentives which encourage overservicing and the practice of defensive medicine, both of which may issue from the need to ensure quality care, and clinicians' exposure to malpractice suits are issues which need to be placed on the policy agenda for discussion and possible reform implementation.

6.3 Measuring Patient Satisfaction

The consumer ethos has generated strategies for measuring patient satisfaction of treatment outcomes. The ideal outcome of treatment is a return to the normal or usual quality of life for a given age and medical condition, and the search for a reliable measure of how people perceive their health. In terms of clinical satisfaction, the American short form (SF36) health survey questionnaire is a standardised self-reported measure of functioning and well being, and is used both in the USA and other countries which have adapted it for measuring outcomes. [To protect the standardisation of the SF36 and to ensure comparability across studies and countries, and to ensure its widespread availability without any fee, the copyright for SF36 and the trademark were placed with the Medical Outcomes Study Trust. See Ware 1993; Garratt et al 1993] Other measures of patient satisfaction however are purely market research instruments:

"little more than clever industrial psychology, convincing patients that their comments are important when in fact they have no bearing on actual decisions taken." (Saltman 1994, p.209)

Surveys which ask patients to rate the various elements of the services received are inherently flawed, because patients on the whole do not feel competent to judge the knowledge and skill of professionals, and many an opinion will be distorted by feelings of gratitude or that the doctor knows best. Satisfaction surveys, and the supply of
information to patients, are often used to create the illusion of power-sharing, raising the frustration level of patients because, while the structure of the delivery system remains the same, the information cannot be utilised.

"Patient satisfaction, it should be firmly understood, is not always synonymous with good medical practice." (Pickering 1996)

The use of patient satisfaction surveys as part of a strategy to address the patient as a consumer, reflects an understanding of the role of the patient as an object of the system. On the other hand, the patient as a consumer with rights to participation in the decision-making process, has an active role and is the subject of the health care system. In the latter situation, the patient is empowered. The reforms to health care systems, however, have been exercises in cost-reduction, not patient empowerment, and exercises in consumer consultation and value-laden guidelines have been used as a cloak to disguise political decisions on funding. (Pollock, Brannigan & Liss 1995)

6.4 Institutional Level Management

In practical applications, quality of care issues at meso-level have so far concerned the implementation of classification schemes such as diagnosis related groups (DRGs), which when used as the basis for reimbursement, give hospitals the incentive to discharge patients early, thereby shifting costs to other sectors of the health care system and in the process risking the patient's return to good health. The use of case-mix measures as an amelioration to the blunt-instrument effect of DRGs are 'far from the holy grail'. (Pollock 1996, p.604)

"First, comparisons between case-mix measures can be difficult, especially when the clinical and social rationale behind the measure is difficult to follow. Second, the measures relate to current levels of service provision rather than service needs, and audit of the appropriateness of services has not been undertaken. For
example [in nursing homes], higher reimbursement for clients with incontinence, nasogastric feeding tubes, and pressure sores may encourage the industry to exaggerate and increase the dependency and frailty of patients. Finally, regulators have not yet found how to use case-mix measures to match reimbursement to service specifications or to ensure adequate monitoring of service quality and staffing levels.”

There have been many and various initiatives tried to ensure quality management, including TQM. Figure 10 lists the initiatives tried in the NHS in the UK.

<table>
<thead>
<tr>
<th>Initiative/Technique</th>
<th>Description</th>
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<tbody>
<tr>
<td>Accreditation systems</td>
<td>Techniques for assessing institutional fitness to practice</td>
</tr>
<tr>
<td>Anticipated recovery pathways</td>
<td>Multidisciplinary methods for planning and monitoring treatments</td>
</tr>
<tr>
<td>Audit</td>
<td>Process for the systematic, cyclical review of the objectives and standards of practice</td>
</tr>
<tr>
<td>Benchmarking</td>
<td>Set of techniques for comparing processes between competing organisations</td>
</tr>
<tr>
<td>Business process re-engineering</td>
<td>Radical review of organisational activities, implemented using the methods of TQM</td>
</tr>
<tr>
<td>BS 5750/ISO 9000</td>
<td>A form of accreditation based on review of documentation of standard operating processes</td>
</tr>
<tr>
<td>Clinical audit</td>
<td>Multidisciplinary, professionally led systematic review of patient care</td>
</tr>
<tr>
<td>Cochrane Centre</td>
<td>Part of the NHS research and development program: it organises systematic reviews of randomised controlled trials and other evidence of the effectiveness of clinical care</td>
</tr>
<tr>
<td>Communications programs</td>
<td>Good communication between providers of services and all their internal and external customers are an integral part of quality management</td>
</tr>
<tr>
<td>Complaints systems</td>
<td>The facilitation and analysis of customer complaints is also important in TQM</td>
</tr>
<tr>
<td>Consumer surveys</td>
<td>Large numbers of surveys and monitoring exercises, of varying quality, have been conducted by NHS agencies since 1990</td>
</tr>
<tr>
<td>Disease management</td>
<td>Term commonly applied to health care quality management initiatives funded or run by the pharmaceutical industry. Also linked to the US term 'managed care'</td>
</tr>
<tr>
<td>Effectiveness Bulletins</td>
<td>Produced by academic teams in York and Leeds as a part of the research and development program's push towards evidence-based care</td>
</tr>
</tbody>
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......continued
External probity and VFM audit: Includes NHS studies such as those commissioned by the Audit Commission. External audits may have either or both policing and developmental functions.

Inspectorates: Public service health and welfare inspectorates include the Health Advisory Service and the Mental Health Commission.

King's Fund organisational audit: A form of accreditation and linked developmental support run by the King's Fund, an independent policy and educational institution.

Medical/Professional audit: Unidisciplinary audit.


Patient focus: An approach originally developed by US management consultants, designed to ensure that patients' 'journeys' through care processes are timely and convenient.

Performance indicators and targets: As contained, for example, in the Health of the Nation program.

Protocols/guidelines: Sets of treatment options and agreed decision making criteria, which may serve as a basis for systematic evaluation of clinical and allied care standards.

Quality of life measurement: There are now over 400 English language instruments available for assessing quality of life, either in relation to specific conditions or overall wellbeing.

Quality management assessment systems: A form of organisational audit. Examples include the Malcolm Baldrige award in the US and the European Quality Award.

Risk (and claims) management systems: An approach to quality improvement based on techniques designed to minimise the risk of unwanted events for which the organisation might be liable or otherwise incur costs.

TQM: Techniques which seek to enhance organisational sensitivity to customer requirements and optimally involve everyone in an organisation in meeting them.


6.5 Macro-Level: Quality of Care and Internal Markets

As Taylor (1996, p.626) notes, maintaining and improving standards of service and care are central to professionalism in health care, and strong institutional structures underpin most health care professionalism. The origins of the bodies which now
represent and regulate medicine, nursing, pharmacy and other health care sector professions

"are closely related to the need to protect the public from 'quackery' and the excesses of competition. This is appropriate in a service where users - patients - are often profoundly vulnerable."

Prior to the NHS and Community Care Act 1990 in the UK, quality of care was the focus of much attention from health care staff. The perceived need was to ensure that quality of care underpinned the introduction of the internal market (i.e. the funder-provider split). (Pitt 1993) There was concern to ensure that price would not dominate quality in the contracting process. There are, however, too few formal mechanisms to define and monitor the standards of care achieved. Accreditation, which is a strategy with a set of national standards and a monitoring process for the organisation of services, was considered and rejected in the UK, although this mechanism is used in Australia, Canada and the USA. The belief in the UK was that external regulation would not be appropriate, and that the contracts negotiated between providers and purchasers would be the most effective means of assuring quality - i.e. leave it to 'market forces' implied by the concept of competition. Contracts were to contain explicit standards or measures and purchasers were to be responsible for monitoring compliance. It is not clear, however, that any accountability from purchasers and providers was to be accorded to patients, other than the accountability aspect of the clinical provider's fiduciary role. Thus the situation continued whereby system problems, such as lack of adequate resources and therefore fewer treatment modalities offered to patients, were still attributed to medical professionals.

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From a patient's perspective 'quality' care probably includes being treated with respect, being given information with which to make informed decisions, and being included in the decision-making process in order to retain some control over the health-care episode. Patient-focused care therefore relates to the patient's perception of care. Pitt (1993, p.28) defines patient-focused care as

"the protocol for managing the health-care requirements of an individual through innovative, competent and practical use of resources; it must challenge purpose, question organisation and promote choice, and value benefit and change."

This still leaves a question relating to accountability towards patients - who is to judge quality, and what structures and processes are available for redress? Self-employed medical practitioners operating at the micro-level are not overseen by any regulatory body for their clinical work. Accountability and quality of care must therefore be dealt with in the main at the meso (institutional) level.

7. Conclusion

This chapter has discussed issues of vital concern to clinicians and patients. Policy makers have yet to address these issues in any depth, and the reforms being made to health care systems are pushing these concerns further away from the discussion agenda. Reforms are minimising clinical autonomy and turning clinicians into technicians, at the same time causing conflicts of interest to the providers of health care. These results are lowering the quality of care, which is already suffering due to the unfocussed budget cuts to health care systems. The attention placed on the changes to management procedures in an effort to maintain quality of care is welcome, but will be of little help if the major players, the clinicians, are devalued and
demoralised. Ultimately, leaving such important issues as appropriateness of care and quality of care to the vagaries of the market place will come to be seen as the ultimate insult to the once proud traditions of providing health care in Australia, UK, NZ and Canada. For policy makers in these four countries to put in place policies and procedures which will ultimately emulate the mess that is the health care industry in the USA is to question not only their abilities in their chosen profession, but also their intelligence in blindly following such a path. It is long since the time when someone should have questioned the sartorial status of the emperor.
Chapter 7. HEALTH CARE REFORMS

"Health care reform in all countries has been a search for the Holy Grail, often poorly informed by evidence and driven by sustained advocacy." Maynard and Hutton (1992, p.2)

1. An Overview of Reform Strategies

The overriding issue has been perceived as demand for health care being greater than resources, leading to cost reduction/restraint in health care budgets. The trend over the last decade has been for all countries to search in the same direction for better ways to provide services and to curtail the growth in costs. (Frenk 1994, Hsiao 1992, OECD 1992) The fact that each of the five countries had large deficit budgets meant that health care budgets have been viewed as candidates for wholesale budget cuts. There was also the common theme of the reappraisal of the role of government, giving internal consistency to the reform movement in each of these countries. (Scott & Gorringe 1989) In the UK and NZ in particular, the welfare state was the target for reduction. Rudolf Klein has observed that health care reform, like other public sector management reform, rapidly became an epidemic, a search for utopia (Klein 1993 p.752). It is contended by others, notably non-economists, that one of the major problems associated with the reforms is that both evidence, (meagre as it may have been), and advocacy, (fervent as it was), was economics-based, without the benefit of argument from moral philosophy which would have informed the debate on the ethics and equity issues so necessary for public policies dealing with a social good as health care is, or ought to be, regarded. (Callaghan 1992; Daniels 1982; Fuchs 1993; Stoffel 1994) As Mechanic (1995, p 1491) notes:
"Tensions are inevitable between funders seeking to solve specific health care issues within existing frameworks and many social scientists who see health and health care as reflections of societal stratification and processes of power and control. Many current and impending issues require deep scrutiny of values and meaning systems as they relate to class, gender, ethnicity and other forms of social differentiation. ... The contributions of the social sciences to understanding complex organisational arrangements, structures, cultures, managerial approaches, financial arrangements and regulatory processes are increasingly evident and part of a culture of informed thinking."

The reforms were firmly based on the principles of ‘economic rationalism’, with the attendant assumptions that human behaviour is primarily economically driven, and the health care market might be not too dissimilar to other types of markets. This led to the diagnosis of inefficiency and a prescription for competition. But the rational choice approach is showing its limits.

"Critics now underscore that [the assumption] that individuals compare expected benefits and costs of actions prior to adopting strategies for action, is valid and useful only in relatively simple choice situations where information is easily available and interpretable." (Keraudren 1996, p.71)

One of the major advocates for competition as a remedy for the problems of health care systems was American economist Alain Enthoven. (Enthoven 1980, 1985; Enthoven & Kronick 1989) The market-oriented reforms followed closely upon a decade of management changes to the National Health Service (NHS) in the United Kingdom and New Zealand's national health care system, while in Australia and Canada, the respective Medicare systems had been subjected to extensive administrative changes. In the USA, costs associated with the free market health care industry during the 1980s had escalated from 9.2% of GNP in 1980 to 14% in 1992. (OECD 1994b) In 1996, it was approaching 16%, (while the other countries remained around 8%), and projections to 2020 gave a growth to 22.7% of GNP if changes are not made. (Pauly 1995, p.79) Consequently, the changes made to the
government programs in health care were largely of a cut-back nature, making access to health care even more difficult for those most in need. Within the private provision of health care sphere in the USA, Enthoven's ideas of managed care took shape in the form of health maintenance organisations (HMOs), preferred provider organisations (PPOs) and independent provider organisations (IPOs), with the hope that these regulatory bodies would help to contain the burgeoning costs. Thus in all five countries, reform had followed upon reform, with little evaluation of results before the next change was forced upon the respective systems.

1.1 Quasi-markets in Health Care Provision

The reforms, introduced in the context of new public management and competition policy, presented real dangers to the objectives of equity and the quality of health care provision. There are inherent dangers in changing the ethos and culture from 'public service' to 'competition through quasi markets', although it is obvious that economic efficiency is a desirable objective, and waste of resources within the system is unacceptable. While the influence of public choice theories and private sector philosophies on the public sphere is an important contributor to the reforms in health care systems in the 1990s, it has yet to be seen whether the outcomes will justify the use of reform strategies based on the philosophies of the market and new public management. (Imershein & Estes 1996; Jacobs & Nilikant 1996; Johanneson 1995a; Kronick et al 1993; Young 1990)

Self (1993, 1995) warns of the dangers of public choice theory and market-based reforms, especially to such concepts as equity, accountability and co-ordination, and suggests that

"public administration, under the influence of economic rationalism, is in danger of being turned into a mere auxiliary of the international market and
monetary system. As a consequence, the distinctive tasks and responsibilities of government are being forgotten, and the change is being justified by some bad economic theorising." (Selk 1995, p.341)

Concomitant with new public management concepts has come consumerism and the ‘user pays’ concept.

“A feature of recent political developments has been the discovery (or rediscovery) of the ‘consumer’. This has been linked to doctrines of the right that emphasize markets and consumer sovereignty and of the left that seek to stimulate grass roots political involvement. It has also been accompanied by an outpouring of political rhetoric and, to a lesser extent, political initiatives that seek to draw consumers more closely into the public policy arena.” (Jenkins & Gray in Mayne et. al., 1992)

Reforms ushered in ‘quasi-markets’ or ‘internal markets’ with techniques such as purchaser-provider split, contracting-out, managed care and general practitioner (GP) fundholding, in the hope that such supply-side competition between providers would introduce efficiencies and stem the escalation of costs in the health care sector in each country. The market model of the health care system predicts that public initiatives to extend financial coverage of health service costs will generate excess demand, increased consumption, higher unit costs and a larger share of national resources appropriated to the production of health services. (Scotton 1989)

An examination of the systems in the US, Canada, the UK and Australia would appear to disprove this prediction. The mainly private (60%) system in the USA does all of these things and has worse outcomes than other OECD health care systems. White (1993) notes that the debate about health care cost control often poses a false choice between bureaucratic and market-oriented approaches. Effective cost control requires budgeting, and it is professional judgment which is required. The important choice is not between markets and bureaucracy, but rather which decisions should be made by physicians and which by managers. This is the
point of contention in all systems, not just the USA's, as clinical autonomy is eroded by new public management concepts.

1.2 ‘The Internal Market’

The internal market is the name given to the separation of funders and providers of health care. (see Glennerster & Le Grand 1995; Bennett & Ferlie 1996; UK Health Policy Network 1995; Maynard & Bloor 1996; Spurgeon 1994; Le Grand 1994; Ferlie 1994) The UK, NZ and some Australian states have adopted the concept in practice. (see Howden-Chapman 1993; Howden-Chapman & Ashton 1994; Borren & Maynard 1994; Malcolm & Barnett 1994) Mason & Morgan (1995) describe the international dimension of the purchaser-provider split by detailing the new arrangements for the UK, NZ and Australia, and they identify the responsibility for funding, purchasing, providing and ownership in each country. Ostensibly, the delivery of services through agreed contracts, which would be open to competition between providers, would be the basis of this internal market. In the UK, the general practitioners' fundholding scheme provided some form of competition between specialist consultants, as hospitals, running out of money before the end of a financial year, began courting the GPs for business through their consultants. There is some evidence that GPs have been able to secure better value for their health care money, as well as better and more prompt service, from the hospitals chosen to provide their patients' care. Fundholding GPs appear now to be treated with more respect by consultants, who depend on the GPs to provide their patients and therefore their income. Glennerster et al (1993) argue that fundholding is probably one of the few parts of the reforms in the UK that is having the competitive efficiency effects on the hospital system for which the reformers had
hoped, although, as it applies to a minority of patients, it may well be having an inequitable effect. Shiell (1992) warns of the effects the introduction of competition is likely to have on the quality of hospital services; given that the outcome is uncertain it is possible that competition may improve some dimensions of quality while jeopardising others. Shiell proposes that the impact of competition on the quality and outcomes of hospital care should be examined in any attempt at introducing managed competition in Australia. The idea of the internal market is to introduce the incentive of microeconomic efficiency which exists in the market place into a system of medical care which does not depend on an individual patient's ability to pay. Internal markets have been operating for several years now in the regulated environment of the health care systems in UK and NZ, and comparative analysis with these markets and the more open markets of the USA may provide pointers for policy-makers. Economists need to know if it is actual competition which is required, or if contestability within the system is a sufficient threat to ensure that equity and quality of care will be taken into consideration by providers. Non-economists would argue that the clinicians (as providers) already take great care in terms of equity and quality. Institutions-as-providers must do the same. After the first three years of operation of the internal market, the UK Department of Health published guidelines (The Operation of the Internal Market: Local Freedoms, National Responsibilities) addressing four major issues which had been identified. Le Grand (1994) analyses both the issues and the guidelines proposed to overcome the problems:

1. Mergers between providers present difficulties for markets. While the creation of bigger units may result in efficiency savings through economies of scale,
these larger units might monopolise the market, operating against the interests of purchasers and patients. The guidelines permit mergers where the resulting institution provides less than half the services within the given market, which is defined in travel time: 14-19 minutes for accident and emergency services; 30 minutes all other services.

2. Mergers between purchasers, again often justified by economies of scale, present difficulties for the operation of the internal market by becoming further removed from local people and local GPs. This weakens the purchaser's ability to take into account all the diverse requirements of the people whom it is supposed to be representing. Patient choices may be limited by the use of block contracts with a single provider. The guidelines require that measures are in place to ensure that patients' and GPs' views are heard and patients are offered choices.

3. Another problem concerns the fate of providers who cannot compete with others in terms of quality and efficiency and whose institutions would fail in an open market. Pressures to bail out failing hospitals have proved irresistible, and the guidelines have provided a set of procedures to follow in cases of 'provider exit'.

4. The problem of collusion offers opportunities for providers to exploit market power and to act as monopolies. But the culture of the NHS has been based hitherto on co-operation, and one person's 'collusion' can be another's 'co-operation'. But collusion between purchaser and provider may prevent the entry of another organisation which offers better quality services, thus reducing patients' welfare. The guidelines point out that such acts would violate not only British company law on restrictive practices, but also European competition law. Le Grand argues that if the guidelines are followed through, then the health service - its
patients, its purchasers and its providers - will be better for it, even though there are several issues not mentioned. There is nothing about management costs, which have escalated, or about the premature discharge of patients, which affects quality of care. Both are issues of political import.

Another example of the climate of competition providing unintended consequences was reported in The Lancet (16 March 1996 p.755). Pressure on UK NHS trusts to save money has resulted in hundreds of tons of clinical waste, ‘including amputated limbs, placentas and used syringes’, being dumped on open land by rogue contractors offering a cheap service. The contractor won a number of contracts on the basis of low competitive tenders “which now appear to have been deficient in providing the appropriate safeguards”. The problems of clinical waste disposal had been anticipated by the British Medical Association in an environmental report published in June 1994, which warned that “years of under-investment have led to a situation where most hospital incinerators would not meet the higher standards required from 1995 under the Environment Protection Act”.

The report added that the application of market forces in the NHS has led to a

“more isolationist approach, such that if one trust were able to identify significant cost savings it may not share that information with other trusts competing to provide clinical services. The result is a reduction in the degree of liaison, networking and information-sharing that takes place in the NHS”.

These are but two examples of the paradigm change from old-style public administration to the new public management proving that a transitional period of adjustment is required to enable acculturation to a significantly different environment.

1.3 Managed Competition
'Managed competition' is the concept of structured competition within the private sector, which was used as a blueprint for the US reform proposals. Its central tenet is to divide physicians and hospitals into competing economic units - called 'accountable health partnerships' - which would contract with insurance-purchasing cooperatives to provide standardised packages of medical benefits for fixed per-capita rates. The precursor to managed competition was the enactment of the Health Maintenance Organization Act of 1973, originally proposed by Paul Ellwood to the Nixon administration, as an alternative to the fee-for-service provision of medical care. Managed competition focuses on the price of the annual premium for a particular package of comprehensive health care services, not the price for individual services. The competition therefore occurs among the integrated financing and delivery plans which offer similar benefits to consumers. Enthoven has been refining and articulating the concept of managed competition for the past 15 years. (see Enthoven 1988, 1989, 1991a, 1991b) The concept is defined as a purchasing strategy to obtain maximum value for consumers and insurers, using rules for (price) competition derived from microeconomic principles. Managed competition is based on a belief that economic incentives are the principal determinant of how patients, payers and providers behave when they seek finance or render medical care. This assumption must be questioned, and work needs to be done on establishing the attitudes held by all stakeholders towards the provision of health care. Consumers are encouraged to make quality-conscious as well as cost-conscious decisions, and providers are encouraged to serve both high-risk and low-risk populations. The emphasis is on decentralised private markets. Managed competition is intended to reorganise the health care market by realigning the
relationships between patients, payers and providers. (Iglehart 1993, p.1209) Managed competition, and the other major component, the capping of total expenditures on health care, in the proposed reforms for the USA health care industry, involves new relations between federal and state governments, between the public and private sectors and between health care finance and health service delivery. According to Enthoven (1993a, 1993b, 1994), managed care plans have not been able to slow down the USA's national health spending, even though there is evidence that these plans can reduce costs and they do offer value for money. One explanation is that the practices of purchasers (including governments and employers), the tax laws, and other market imperfections have reduced the demand for real cost containment, depriving managed care plans of an adequate incentive to cut cost and price. White (1993, p.51) sees managed competition with global budgeting as an effort to displace blame from politicians to the managers of the plans. Global budgeting requires premiums to be set, and other countries do this by setting rates, budgets and capital costs. Relying on managed care to set premiums is most likely to produce politically unacceptable delivery of services. Altman & Cohen (1993) and Aaron & Schwartz (1993) also see the need for a national global budget, and without budgetary limits, there can be little cost containment. The ability of other countries to keep down their health care costs with the use of global budgets appears to provide the evidence for these views.

1.4 A Culture of Competition in Health Care Provision

The culture of competition introduced with quasi markets is antithetical to the medical profession's collegiate culture. The introduction of the funder-provider split was intended to cause hospitals to compete with each other and provide choice for
the funders. Inefficient hospitals would in theory be closed. This concept may make economic sense where all hospitals provide exactly the same services, but this is seldom the case. Some hospitals may specialise in specific areas of treatment, others may attract the more severely ill. Hospitals cannot be compared in terms of their input and output of resources, unless adjustments are made for many variable factors. Hospitals which were deemed inefficient and were supposed to close down, were kept operating in the UK because it was not politically acceptable to close them. Canada is now experiencing this dilemma. (C. Gray 1995) Inefficient hospitals in New Zealand were given extra resources by the government, thereby defeating the object of the reforms. (BMJ 1994; 308:556-7; The Lancet 1994; 343:723, 967) If access to hospitals is seen to be a necessary condition for an equitable society, then hospitals will be required in areas which may not be able to economically support them, providing more evidence that competition in the usual sense of the word does not work efficiently in the area of health care provision.

2. Results of System 'Reforms'

Results of reform in health care systems show that factors other than rational choice are operating in the health care environment. The reforms have created what they had assumed: economically-driven behaviour. In a context of weak and restricted competition and other market failures, this disruption of well-established patterns of service ethics has led to cost-shifting, defensiveness rather than enterprise, careerism and occasional corruption. (Light & May 1993 re: the NHS reforms.) Certainly the tenets of 'economic rationalism' have induced technical efficiencies at macro and meso levels, in that total health budgets have been cut and hospitals no longer have the capacity to operate in accord with quality standards. Thus the
objectives of macroeconomic cost control and some objectives of microeconomic efficiency have been achieved in most countries (USA excepted) but at the expense of the third objective of health care, namely equity and many of the other microeconomic efficiency objectives such as quality of care, consumer satisfaction and the most important goal of improving health status, especially within those groups with unsatisfied health care needs.

2.1 Containment of costs

Where the health care system is mainly provided by public funding, such as the UK with 84% government share, costs are contained by rationing services usually with the aid of waiting lists but latterly by the cessation of certain services, and results raise doubts about the equity and fairness of this strategy. There is also doubt about the validity of waiting lists to show the real position, as these tools can be manipulated for political purposes. Where systems are more market-driven, such as in the USA where only 42% of funds are provided by government, costs are controlled by the regulation of investment in hospitals, by the imposition of prospective payment mechanisms, such as DRGs and capitation, and by manpower licensing. Reforms have tried to combine the relative advantages of both systems, and a convergence towards a public-private mix has emerged with strategies such as managed care, which provides for mini-national health services within market environments, and an opening up to competition by way of funder-provider split in more regulated environments. (See Ginzberg 1987; Fuchs 1987; Kronick, Goodman & Wennberg 1993; Iglehart 1994a; Jellinek & Nurcombe 1993; Relman 1993a, 1994; Shapiro 1994; Clancy & Brody 1995; Rodwin 1995) But where funding cutbacks are implemented, without a reconsideration of how health care is
delivered, such as is happening in Canada (Rachlis & Kushner 1994) and Australia, then the health care system is in danger of disintegration. Cost cutting which is not based on appropriateness of service as a guide, but rather on economic necessity to lower public deficits, will lead to underfunded public hospitals, fewer health programs, lower quality of care and indeed lack of care to many in medical/clinical need.

2.2 Equity

When the ethic of provision of public goods and services, such as existed in the UK up until 1979, is replaced by ‘customer service’ emphasising economic rather than social considerations, then the concept of equity is liable to be downgraded. The introduction of (ineffective) ‘consumer committees’ was supposed to ensure accountability, especially when dealing with issues of social equity. Consumerism has removed the emphasis on social citizenship and NPM has displaced the public service ethic, making public utility services little different from other commodities, a situation likely to result in long lasting economic and social damage. There has been some convergence in reform strategies with regard to access to care in the solidarity principle which stipulates ‘vertical equity’ (different treatment of different individuals in the financing of care) and ‘horizontal equity’ (equal treatment of equal individuals or equal need in the provision of care), (see Carr-Hill 1994a, p1191), meaning that each citizen contributes according to ability while receiving treatment according to need. (Chernichovsky 1995, p.342/3) Certain systems however, notably in the UK and Australia, need to address the problem of low private health insurance cover, and should be encouraging people to lessen the burden on the public provision of health care.
2.3 Shifting Boundaries

The boundaries between health care needs and welfare needs of different groups within a society shift according to the medicalisation of social ills. (Hurowitz 1993; Mechanic 1993, 1995, 1996) The boundaries between the political and the administrative spheres of influence shift with new organisational and managerial techniques. (Starr & Immergut 1987, Vinter 1993) The degree of patient autonomy and clinical autonomy, and the effect of consumerism and the concept of 'patients' rights', alter the boundaries of the doctor-patient relationship. (Charles & De Maio 1993; Kassirer 1994; Pollitt 1988; Potter 1988; Saltman 1994; Tailor & Mayberry 1995) Changes to the locus of power in intergovernmental relations shift the boundaries in federal/state responsibilities and hence of both funding of health care and provision of health care programs. (Butler 1991; Chapman 1984; Fletcher & Walsh 1992; Gerritsen 1990, 1992) The increase in complexity which causes such shifts is brought about by population changes, such as an aging society, epidemiological changes in mortality and morbidity and changes in technology which provide more and greater tools for clinicians to use. Management practices which have altered the focus from inputs to the system to outputs and then to outcomes (Duckett & Swerissen 1996; Terris 1988) have been responsible for increases in complexity, underscoring the need for bigger and better data and information systems, as well as a degree of intelligence and ability from policy makers which is not presently in evidence. (Anand 1995; Bloomfield 1991; Boyce 1996; Britt & Miller 1993; Davenport et al 1996; Fleming 1991; Gold et al 1995/6; Gostin 1993; Henderson 1991; Hindle & Scutari 1988; Krieger 1992; Miller & Britt 1993; Shiell 1993)
2.4 Evaluation of Results of Reform

The OECD study of health care system reform found that:

"The most remarkable feature of the health care systems reform across the 17 countries is the degree of emerging convergence. Whether intentionally or not, the reforms follow in the general direction of those pioneered earlier in other countries." (OECD 1994a, p.45)

This conclusion of 'emerging convergence' is not surprising, given that reforms in OECD countries stem from the twin pressures of fiscal restraint and increasing health care demands. However, while the outcomes may appear the same, many will differ in significant ways, as will the process by which the change has come about. A topical case in point is that of contracting for health care services within a health care market. The UK adopted quasi-markets for the purpose of contracting in the hope that the introduction of competition may reduce costs. A comparison of US and UK contracts, however, illuminates the fundamental differences of the two systems. The US contracts emerged from a true private market, while UK contracts continue to exist in a managed public system in which the central government is always present as an unnamed partner. Ultimately, the UK opted for 'contestability' rather than 'competition', because true competition was impossible in the NHS.

"In the end, perhaps the most important lessons to be drawn from the comparative reading of purchaser/provider contracts is the extent to which traditional relationships persist in health care delivery systems despite the legal structures that are imposed upon them." (Jost et al 1995, p.905)

It is as well to remember Klein's (1991, p281) warning about the role of the OECD and the use of the economics-based statistics emerging from the comparative studies made by the organisation.

"By generating these data OECD was of course, also subtly helping to shape the nature of comparative enquiries ... and the focus and methods of those
engaged in comparative studies are inevitably influenced by the nature of the available data."

Carr-Hill (1994a) has reviewed the evidence about effectiveness, efficiency and equity at the macro level of health care reforms. Among OECD countries, there is little evidence that variations in the levels and composition of health service expenditure actually affect levels of health status. Whilst geographical redistribution of finance has proved to be possible, inequalities in health remain in most countries. Equity in financing and delivery appears to mirror equity in other sectors in the same countries, and the only conclusion which Carr-Hill found to be transferable was that costs can be contained best via global budgeting. But his overwhelming impression of the studies of health care reform is that the quality of the data bases used “is appalling, and the analytic techniques used are simplistic.”

As Chadwick (1993, p85) makes clear, while efficiency is desirable, it is most important to have a method of priority that is fair, with considerations of justice occurring at all levels of priority setting. And as Hancock (1993, p.20) points out, we need to establish a moral principle about who gets treated and for what need. Mechanic (1977) pointed out twenty years ago, and which holds true today:

“As people have learned to have high and more unrealistic expectations of medicine, demands for care for a variety of conditions, both major and minor, have accelerated. No nation that follows a sane public policy would facilitate the fulfilment of all perceptions of need that a demanding public might be willing to make. As in every other area of life, resources must be rationed.”

2.5 Macro-Level Outcomes

The logical outcome at the macro level of health care policy with its focus on cost reduction is the rationing of health care resources. But this is a very emotive, and therefore highly political, issue, leading one Secretary of State for Health in the UK
(Virginia Bottomley) to forbid the use of the ‘R’ word, and enforce the use of the phrase ‘resource allocation’ as preferred terminology. Semantics, however, doesn’t change the fact that policy makers have been focusing in the wrong area, and have accordingly been asking the wrong questions. OECD research has long since proved that countries with a capped health care budget can indeed keep overall costs down. The problem then becomes: with infinite demand for health care services, and capped resources at an average of 8% GNP, who is going to decide which patients will receive treatment and who must go without? Or, which treatments will be readily available, which will be rationed and which will not be available at all? On what basis will such decisions be made? The attachment to health economics has seen a quest for formulae to inform these decisions, e.g. QALYs and other cost/utility measures, and the outcome has been the removal of the decision-making process from medical practitioners, who are the only ones qualified to make judgment from a medical-needs basis, to lay managers who make the decisions according to the ratio between cost and utility. Only discussions, at all levels, with all stakeholders, can begin to bring out the arguments of this issue, and even then there can be no magic formula by which such decisions can be made. There is no possible way to deduce that a hip replacement in a 98 year old patient has more or less utility than a cataract extraction has for a 60 year old, but this is what such formulaic problem-solving is presumed to be able to do. Not that there is the slightest pretence that the problem is stated in terms of ‘what is best for the patient?’, but ‘how do we get the best value for our health care budget?’.

Cost control is easiest when monopsony power is available (Saltman 1992), so that there is either a single funder where all funds flow through the one budget,
or through consultation between funders to formulate overall spending constraints. The hospital sector is the major area involved, although spending in both pharmaceutical and ambulatory care areas is being investigated for more control. The techniques of control include the use of prospective budgets for hospitals, with funding formulae dictated by DRG/Casemix concepts (Donaldson & Magnussen 1992; Fetter 1985, 1986 Fetter & Freeman 1986); the regulation of numbers of hospital beds; distribution of new facilities; controls on manpower and pay rates; and the regulation of new technologies and their dissemination (Selby-Smith, Hailey & Drummond 1994). Control over pharmaceutical spending includes the restriction of products through positive and negative lists, which dictate which products may be sold and which can be reimbursed by insurers.

The marked slowdown in the growth of spending in the public sector during the 1980s has been attributed generally to the efforts of government macro-controls on spending. Macro-budget constraints alone, however, rarely appear to have encouraged greater efficiency and effectiveness of providers, and in some cases may have weakened the achievement of those objectives. (OECD 1994b, pp. 29,30)

In the five countries under review, the difference between the USA and the other 4 countries is one of magnitude. Australia, Canada, NZ and UK each have instruments by which expenditures on different segments of the system can be kept within nominated bounds. Because each of these countries has a national system, or state/provincial systems within a national framework, each government can vote a global budget to at least part of the system. Monies are then apportioned according to agreed formulae to the various parts of the health care system. Reforms are required to keep various parts of the system in balance, and to ensure equity of
access across the entire society. The USA, by relying on the market to apportion health care, has no such instrument, and at a national or federal level, has very little power to contain costs, other than in the several federal programs of health care. The result in the USA has been a plethora of regulations, which only add to the overall costs by requiring more and more paper-work from insurers, providers and patients. Reform of a structural nature is required in the USA, but it is difficult to see how this will ever come about, given the nature of American politics and governance. (Wolfe 1993) The health care industry is profit-driven and controlled by commercial concerns. The government would have to remove the power of vested interests, especially the insurance industry and the pharmaceutical industry, before a health care system emulating the other countries could be considered. This is not likely to ever happen. There is a model in the USA for federal control of publicly provided care and that is the Veterans program. Presently, the one hope for people without insurance is for the states to address the problem, rather than leave it to the federal government. Many states have reformed, or are in the process of reforming their health care arrangements. (Bergthold 1990; Cantor 1993; Caplan & Ogren 1992; Hadley 1992b; Hackey 1993; Iglehart 1994d; Kronick 1990; Lewin & Sybinsky 1993; Miles et al 1992; Moon & Holahan 1992; Sparer 1993) Perhaps the need for reform in the USA has more to do with morality than economics. (Menzel 1995) The current health care industry constitutes 7% of American business, and radical change would be a major upheaval. But if the 37-40 million uninsured people are to be afforded even minimal coverage, then the community must agree to funding this coverage. Further, if the USA does not want to spend more than 14% of its GNP on health care, then the spending by the very affluent on health care
must be curtailed to the extent necessary to redistribute the available health care. Or taxes must be raised, and American public opinion has refused this option. As long as the structure allows patients to purchase whatever health care they demand, and allows providers to accede to these demands, there appears to be no way in which the USA can control the amount spent on health care. As philosopher Paul Menzel asks:

"If the cultural bedrock...is simply an individualist moral orientation in which citizens are not ashamed to reveal their self-interest in publicly justifying their views on health policy, will [the USA] ever be persuaded to support universal coverage of basic care? Must there be a major change in the moral culture itself, or might we instead see our way through to universal access on the foundation of our existing moral culture?" (Menzel 1995, p.68)

2.6 Shifts in the Focus of Reform

The current trend is towards competition between individual doctors and between hospitals, in the hope that the 'internal' market will play a role in keeping down costs. (Shiell 1991; Whynes 1993) In practice, however, the reforms to the health care systems in Australia, NZ, UK, Canada and USA do not show evidence of having attained objectives other than cost reduction, usually by the gross means of budget cuts and the cessation of services. There have been some improvements, such as the setting-up of Cochrane Centres, but results from clinical trials will take many years to achieve, and even then there is no guarantee that policy makers will reflect those results. Where clinical services have been deemed to be ineffective, they have been taken off the public list. There has been no attempt to coordinate public policy to alleviate ill health from adverse economic policy, nor is there enough funding to pursue basic research into the cause of various disease states. The ideas of the 1970s emphasising rational planning and policy analysis were
modified by a shift in focus to the effective management of state activities. (Lindquist & Murray 1994; McInnes 1990, 1993; Pollitt 1986, 1990, 1991; Rayner 1995; Zeckhauser & Leebaert 1983) Table 12 below depicts the shift in the focus of reform strategies over the decades from the 1970s.

Table 12 Shift in Reform Focus

<table>
<thead>
<tr>
<th></th>
<th>1970s</th>
<th>1980s</th>
<th>1990s</th>
</tr>
</thead>
</table>
| Input      | Orientation
|            | 1970s                | 1980s                | 1990s                |
| Output     | Orientation
|            | 1970s                | 1980s                | 1990s                |
| Equity     | concerns
|            | 1970s                | 1980s                | 1990s                |
| Economy    | Efficiency
| Cost-cutting | Search for waste | Search for value-for-money |
| Operations research | Re-organisations | Regionalisation/ |
| # of beds, resources | Centralisation/Decentralisation | Inputs/outputs |
| Health services research: | - small area variation | - RCTs |
|                      | - meta - analysis   |                      |
| Move to "internal markets"
| Competition to increase efficiency
|                      |                      |                      |

Priority was given to resource management and to the creation of a culture of responsible public sector managers, who sought value for money in the delivery of services and to focus more closely on the customer. (Gray & Jenkins 1991; Mascarenhas 1990, 1993; Packwood et al 1990, 1992) The focus on efficiency required new processes for resource management and performance measurement. New structural changes included decentralisation and turning public sectors into agencies, such as the Next Steps initiative in the UK. (Carter & Greer 1993; Greer 1992; Hede 1991; Kemp 1990) Moves to increase efficiencies have included
privatisation. Part of the rationale for these changes was to create a state apparatus more responsive to public needs where the citizen, client or consumer would be better served, and a more responsible and accountable system in which the performance of state activities could be more clearly evaluated. (Hambleton 1988; Hibbard & Weeks 1987, Hunter 1992; Jones 1992) At the same time, more attention was being paid to reducing the demand for health care by increasing user charges. (OECD 1994b)

The major shift in the focus of the reforms since the early 1990s reflects the pressures which are building for countries in the developed world to concentrate more clearly on social justice issues. An editorial in Social Science & Medicine (1994; 38(1):vii-viii) points out that comparatively little is known about the equity characteristics of alternative health care financing and delivery systems, or the likely equity implications of reforms to these systems, because the few cross-country comparisons of health care finance undertaken to date focused primarily on issues related to cost-containment and efficiency. This underlines the problems of data collection and information dissemination, noted in Box 8 of Diagram 1. A study by Doorslaer et al (1993) uncovered three clear clusters of health care financing with three quite different profiles of progressive taxation/insurance payments (i.e. health care payments rise as a proportion of income as income rises). This study, and that of the OECD (The reform of health care. OECD 1992), suggest some questions, the answers to which may provide guidance for health care reform:

- what are the merits of competition vs monopsony (one buyer) among third party payers in a public sector environment?
- in case of competition, how can the cream-skimming of third party payers be sufficiently discouraged?
- in the case of monopsony, does the contract model in internal health care markets produce the desired efficiency gains?
how should consumer choice and third-party negotiations in the hospital market be organised?
what are the current equity characteristics of a system and how do these change under different options for reform?

Table 13 below depicts these trends in terms of the effects on the various segments of the health care system, e.g. departments of health, hospitals and individual clinicians.

<table>
<thead>
<tr>
<th>Depts/Ministries of Health</th>
<th>Hospitals</th>
<th>Clinicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>E ECONOMY</td>
<td>Cost restraint</td>
<td>Operations research Cut-back m/m</td>
</tr>
<tr>
<td>Q</td>
<td>Budget cuts</td>
<td>Cut-back m/m</td>
</tr>
<tr>
<td>U EFFICIENCY</td>
<td>Private sector techniques</td>
<td>Non-clinical areas subjected to scrutiny &amp; commercialisation DRGs (external) DRGs (internal)</td>
</tr>
<tr>
<td>I</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T EFFECTIVENESS</td>
<td>Health status outcomes</td>
<td>League Tables</td>
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<tr>
<td>Y</td>
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The latest OECD study of reforms (OECD 1994a) has shown that reforms have moved systems away from the public integrated model toward the public contract model, where an internal market in health care operates - such as in UK, NZ and some states in Australia. The following questions concerning this type of internal market, posed in this OECD study (1994a, p.50), remain unanswered:

- when buyers and sellers are both public bodies, can the government remain on the sidelines, when there is a public outcry about the closing of a local hospital due to market forces?
- what if doctors insist on acting as a monopoly and refuse to compete?
• how is the conflict between consumer choice of provider and third-party choice of the 'best buy' to be resolved?

• will the extra administrative costs of contracting (on both sides of the market) and the risks of staff payments being bid up by competition absorb any efficiency savings?

• is it possible to find a way to avoid risk selection ('cream-skimming') so that unhealthy patients find it difficult to obtain services?

• how can quality of care be protected?

• will there be sufficient disclosure of information to make the market work as intended?

Given the wide variety of financing, contractual and regulatory arrangements within health care systems, countries have different problems of varying intensity. The UK, which until 1990 had capped budgetary financing of hospital care with salaried doctors restraining medical spending, was concerned with increasing effectiveness, especially reducing waiting lists. The USA, on the other hand, has focussed reform attempts on overall expenditure restraint without loss of quality of delivery and with improving access to care. Neither country has succeeded in attaining these objectives. (Globerman 1991; Iverson 1993; Lunberg 1995; Miller & Luft 1995; Rosenthal 1994; Rothman 1993; United Kingdom. Radical Statistics Health Group 1992, 1995)

Reform strategies differ between countries even for similar problems, because of the different objectives and pressures from stakeholders - providers, patients and taxpayers. Reform efforts have tried to slow the increase in share of public health spending in GDP and in total public expenditure. Tax transfers from the shrinking working-age population to the growing retired population will increase significantly with aging populations. Tax increases or service-cutbacks appear unavoidable, but

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are politically dangerous. The inherent problem of potential conflict from the three primary objectives - equity, efficiency, and cost control - is ever present. Governments have had to balance these different objectives, in part by shifting the emphasis over time as the consequences of past choices manifest themselves. (Macara 1994)

Issues under examination in the mid-1990s include quality assurance, greater accountability of professional practice with increasing surveillance of activity, assessment of spending and measures of outcome expressed as medical audit for individuals and league tables for hospitals and other organisations of providers such as health maintenance organisations (HMOs). This change in focus has shifted the arena of debate, in countries other than the USA, a little away from the macro-level of governance and more towards the meso-level of institutional organisation and the micro-level of medical autonomy - from national politics to the politics (and power) of interest groups, which increasingly include consumer groups. (see USA Center for Public Integrity 1995; Sharfstein & Sharfstein 1994 for the situation in the USA.) As discussed in Chapter 5 above, it is clear that rationing of available resources is a major issue, especially where governments refuse to inject greater funds into health care, and that politicians would prefer that rationing occurs outside their jurisdiction.

One major issue which ought to be driving reform in all countries is the probability that only about 10% of interventions have some basis in cost effectiveness (Maynard & Bloor 1995, p177). If it could be established which treatments work and which work best in given contexts, the problems of cost and quality could be tackled together, with resultant savings to ensure equitable access
to health care systems, and the problem of rationing might not be so acute. The results from Cochrane Centres and other RCTs will be of major benefit if they are correctly carried out, reported and the information disseminated.

3. Examples of Reforms

Reforms driven by economic necessities have had detrimental outcomes on the quality of care in Australia, New Zealand and the UK, in relation to state-funded hospitals, and in the USA in relation to managed care. With the government's objective of deficit reduction in Canada, the problem applies to that country also. Drives for greater efficiency, higher outputs, lower staffing levels and threats of redundancies have occurred simultaneously with a major thrust to customer focus in an environment of more and costlier procedures and therapies. This inevitably leads to stress, and

"an attitude that ignores the internal customer in the system [which] cannot, if the lessons of other industries are any guide, lead to a true quality-focused environment. There is a major need for more studies on the consequences of a politically driven focus on external customers with a failure to recognise the internal customers of the system." (Editorial, Journal of Quality in Clinical Practice, 1995; 15:1-2)

USA is one of gross inequalities with at least 15% of the non-aged population at risk and very expensive, profit-oriented health care provision largely determined by market forces. America's special quality of 'rampant diversity' got in the way of President Clinton's health care reform proposals, against which many pressure groups lobbied extensively and expensively. While Australia, Canada and the UK have introduced reform of varying degrees of innovation, they still provide universal access to free care. The reforms in NZ, however, have moved the health care system away from social welfare towards a more consumer-pays orientation, while
the situation in the USA centred on universal coverage for all Americans and how to control costs. As an Editorial in the *British Medical Journal* points out, the USA is a nation divided by business, ethnic, religious, social and geographic interests, and has a difficult time agreeing on anything.

"Combine this with the historic weakening of the power of the presidency, the political parties' growing fractiousness, and increasingly sophisticated lobbying on behalf of special interests, and the result, in 1994, was stalemate over the reform of health policy." (Rosenthal 1994, p.1383)

3.1 Structural Changes

The changes to the systems in UK and NZ are briefly discussed below. Arguably the most radical changes were those imposed in New Zealand where the major reform of 1993 'almost overnight transformed the regulated health care market to one with substantial competitive elements.' (OECD 1994a, p.29) By 1995, New Zealand's welfare state, one of the oldest in the developed world dating from 1898, had been radically altered (Laugesen & Salmond 1994; Borren & Maynard 1994) Until then, the long-standing interest in welfare statism underscored all economic policies, with the state assuming a key role in the provision of many goods and services and intervening in market processes on grounds of equity. As Scobie & Janssen (1993, p.5) indicate

"Past interventions led to a cancer of new interventions, many aimed at correcting the distortions created by other distortions. By the mid-1980s, the state apparatus was attempting to manage virtually every key economic variable. Interest rates, exchange rates, price levels, labour contracts, imports, transport, capital flows, energy supply, telecommunications, export marketing and investment in R & D were all determined by law, regulation or decree."

Such was the magnitude of the changes wrought that New Zealand has become 'an international case study for countries undertaking liberalisation and structural adjustment'. (Scobie & Janssen 1993, p5) The changes were implemented under
three major pieces of legislation: the State-Owned Enterprises Act 1986, the State Sector Act 1988, the Public Finance Act 1989 and the Employment Contracts Act 1991. (see Boston 1991 and Boston et al 1991) The major structural changes to the health system were spelled out in the "Green and White Paper" of 1991, entitled *Your Health and the Public Health*, released by the Minister of Health Simon Upton. The paper identified 8 significant problems (see Borren & Maynard 1994; Buchan 1993) After an eight-year struggle to reduce the 29 hospital boards to 14 area health boards, the July 1991 budget of the National Government simply abolished them overnight, placing in their stead 4 regional health authorities (RHAs). The major components of the Paper, such as the introduction of fees for public hospital services, were later embodied in the Health and Disability Services Act (1993), the legislation which forms the basis for the most recent health care system reforms. At the time of the announcement, it had been expected to have the new system in place by July 1993. As *The Lancet* recorded,

"[i]ronically, having been admired internationally for the achievement of universal health coverage and a relatively simple funding system, New Zealand looks set to move into a far more complex system, with the potential for discrepancies between the levels of health care received by people according to what they can pay." (Editorial *The Lancet*, 1991; 338:374-5)

The proposals included the division of the role of area health boards into purchaser and provider, which was the major feature of the changes, and one which gives rise to the ‘revolutionary’ aspect of the reforms. Unlike the UK’s purchaser/provider split, the NZ separation extended to ministerial level, with a new minister appointed to oversee the public hospitals, now called Crown Health Enterprises (CHEs). Other proposals included the separation of the organisation and funding of public health from personal health care services; encouragement of competition among
providers; the integration within one agency of the funding for all personal health care; the encouragement of continuity of care and coordinated management across the spectrum of personal health care services; provision of access for everyone to an acceptable level and quality of services while allowing greater freedom of choice for individuals; explicitly defining ‘core health services’ for which government funding would be available; retention of the state's role as the major founder of the health sector; the encouragement of individuals to take responsibility for health care; formalising the system of user charges for the personal health care services; and strengthening and redefining the role of the Ministry of Health as a key policy adviser to and monitoring agent for the government. (OECD 1994a, p237)

Two key bodies were charged with the implementation and monitoring of the changes: a new Public Health Commission to fund population-based public health services, and a new National Committee to advise the government on the core health and disability support services that RHAs must purchase. Core services are defined as those to which everyone should have access on affordable terms and without unreasonable waiting times.

In the UK, there were obvious signs of inefficiencies and wasteful practices within the NHS, but it was nowhere near as ‘broken’ as President Clinton remarked of the USA's ‘system’. Measured by any objective criteria and compared with other vastly more costly health care systems in the OECD, the NHS was highly cost effective, albeit it with lesser quality of care than others. (UK Health Policy Network 1995, p.483) Competition theory had an effect on the management of organisations within the NHS, providing managers with new levers of control and an opportunity to move further towards managerial values in the overall culture of
the NHS. (Editorial *Health Services Management Research*, 1994; 7(3): 210) Like NZ, the NHS not only instituted market-type reforms in a redefinition of the welfare state, but moved towards closer ties with the private health care sector, which existed as a supplement to the NHS and is growing in importance in certain areas of care, notably in relation to non-urgent hospital care. (Salter 1995) Private expenditure on health care comprises some 15% of total health expenditure in the UK. (Ham 1996, p.191) The reform strategies included the funder-provider split concept, the institution of hospital trusts, GP fundholding and the Patient's Charter, all of which echoed the reforms being made generally throughout the public sector. Prior to the introduction of the 'radical' reforms of 1991, the NHS had undergone incremental changes during the 1980s. (Day and Klein 1989; Paton 1993) While some improvements had occurred to management processes in the early reforms following the Griffiths' Report (Pollitt 1991), there had been no substantial change in organisational culture. The Report had had a flawed understanding of the management problems in the NHS, where there are contradictory objectives and multiple perceptions of problems, resulting in uncertainty and ambiguity. There are major differences between the 1983 Griffiths Report (*NHS: Management Inquiry*) and the later reforms, the White Paper *Working for Patients*(1989) and the Green Paper *The Health of The Nation* (1991). Analyses of the latest reforms (Black 1992, Jobling 1989; Scheffler 1992) show them to be more in keeping with an ideology of economic reform rather than an attempt to seek the best health care policy. Klein (1995, p.308) views the reforms as an attempt at reconciling two policy aims: to minimise public expenditure and to maximise the government's own political credit. On the one hand, the government sought to maintain those features
of the NHS that made it such a popular institution, on the other hand, the
government hoped to reconcile its economic and political aims by improving the
NHS's efficiency rather than its budget. The replacement of the welfare model by a
market model shows clearly in the emphases on more choices in the market place
(consumer sovereignty), profit making and financial reward for productivity, in the
general reforms in public administration/management. The later reform proposals
would restructure the relationships between managers and doctors in a market
model of health care, as has happened in the USA.

"Taken together, the proposals represent the most far-reaching reform of
the National Health Service in its forty year history." Margaret Thatcher in the
Foreword to "Working for Patients" (1989)

While the government acknowledged the importance of such sweeping changes, it
denied the need for formal monitoring and evaluation, and as a consequence of this
lack of governmental concern, the King's Fund Institute made the evaluation of the
reforms the focus of a major grants programme during 1990 to 1993. The results
of the seven studies undertaken show that few conclusions could be made at that
stage, except for the apparent success of GP fundholding. (Robinson & Le Grand
1994) According to a report from healthcare analysts Newchurch & Company,
the effects of the government's 1991 health care reforms may now be beyond the
control of politicians and policy makers. The reforms have set in train a process of
restructuring which will affect every facet of UK healthcare, and within a short
space of time the logic of the market will become undeniable. (The Health Service
Journal 16 September 1993, p.4). Table 14 shows the comparison of the old and
new NHS with regard to the funding and management of the health services and
their integration, and the role of GPs and District Health Authorities (DHAs).
3.2 Canada

While Canada has avoided the direct governmental controls of the UK's NHS and the increasingly close monitoring of medical decisions by third-party payers, there are problems emerging with the entire structure of the health care system under stress. (Linton 1990; Evans 1990) As pressures to reduce the growth of health care expenditures and public expectations of their health care system grow, the provinces are finding themselves in very difficult circumstances. Canadian Medicare, however, still provides Canada a universal, comprehensive, portable, accessible health care system offered on a non-profit basis by a publicly administered agency via an interlocking set of 10 provincial and 2 territorial health insurance schemes. Each scheme is linked through adherence to national standards set at the federal level and the Canada Health Act 1984. (OECD 1994a, p.103)
## Table 14  
Comparison of Old and New NHS

<table>
<thead>
<tr>
<th>Old System</th>
<th>New System</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Role of District Health Authorities</strong></td>
<td>DHAs' main responsibility becomes the health of local people. They will assess health needs and decide how best they can be met.</td>
</tr>
<tr>
<td>DHAs have confused responsibilities covering both the overall planning of services and the running of hospitals and other units.</td>
<td>DHAs will be funded to purchase services on behalf of their residents. Funding will, over time, reflect the size, age and relative health of DHA populations.</td>
</tr>
<tr>
<td><strong>Funding of Health Services</strong></td>
<td>Hospitals and other units receive funding from those DHAs with which they agree NHS contracts (or service agreements). These contracts set out the quantity, quality and cost of services to be provided (through the year). This links funding and the activity required to meet identified health needs.</td>
</tr>
<tr>
<td>DHAs funded for the services which happen to lie within their boundaries largely on the basis of historic patient flows.</td>
<td></td>
</tr>
<tr>
<td><strong>Management of Health Services</strong></td>
<td>All hospitals and other units take on greater responsibility for their own affairs, so the people providing services are the ones taking decisions. Some become self-governing NHS trusts, independent of DHAs but still firmly within the NHS.</td>
</tr>
<tr>
<td>Too many tiers of bureaucracy controlling the activities of hospitals and other units.</td>
<td></td>
</tr>
<tr>
<td><strong>Role of GPs</strong></td>
<td>DHAs consult extensively with local GPs on preferred referral patterns and conduct surveys of local opinion as part of the process of agreeing contracts with hospitals on the services to be provided.</td>
</tr>
<tr>
<td>Few incentives for hospitals to respond to the needs and preferences of GPs and local people.</td>
<td></td>
</tr>
<tr>
<td><strong>Integrating Health Services</strong></td>
<td>DHAs (responsible for hospital and community health services) and FHSAs (responsible for primary health care services) both under the management of RHAs, ensuring effective joint working to improve the health of local residents. DHAs new role in focusing on health puts them in a better position, jointly with FHSAs, to achieve a balance of prevention and treatment.</td>
</tr>
<tr>
<td>Very little integration between primary and secondary care, and little attention focused on achieving the right balance of prevention and treatment. FPCs not under management of Regional Health Authorities.</td>
<td></td>
</tr>
</tbody>
</table>

According to Evans (1992b), Canadians see the real issue of concern as one of how to improve the management of a popular, effective and heretofore affordable system, so as to preserve it in a more hostile economic environment. The functioning of the Canadian Medicare system is constantly in the forefront of public debate with ministers of health and provincial premiers, who are held accountable in the provincial legislatures and the press for any problems or misadventures which occur. (Evans 1992b, p.750) Although, as Linton (1990) points out, difficult rationing decisions are left up to management groups or doctors at the local level, and have largely been concealed from the public; but when they are not, each case becomes an identified victim of the failure of the system, becoming a 'media feast' and a serious political hazard. As in other OECD countries, Canada has been trying in recent times to contain the overall costs of health care by concentrating on the reform of health care delivery, rather than the financing of the system. Canada's reform efforts have concentrated on improving microeconomic efficiency, and are not of the same magnitude of change as that in UK, NZ or Australia with funder-provider split and internal markets. However, as McGregor (1995) points out, Canadian health care costs more each year because they provide more services each year. The cost problem will not be solved by saving money through “such praiseworthy measures as total quality assurance, clinical treatment guidelines and technology evaluation”. (McGregor 1995, p.572) Reforms in the public sector in Canada have been a continuous process originating in the 1970s, with focuses on decentralisation, citizen participation and outcome-centred management. (Pineault et al 1993) Lindquist & Murray (1994) made a comprehensive survey of administrative reform in Canadian provinces, to reflect the extent and nature of the
'current tumult' in Canada's public sector. Governments at all levels were in the midst of significant restructuring, a process which 'will continue for the foreseeable future'. (Hurley et al 1994; Jabes 1992; Rayner 1995, Spasoff 1995) The provinces have been reviewing their health services, undergoing stocktaking and adjustment, and changing political traditions in the different provinces (Crighton 1989) The National Forum on Health formed by Prime Minister Jean Chretien in October 1994, is providing opportunities for all Canadians to discuss the perceived problems of their health care system, and offer solutions to those problems. The Prime Minister spoke of the need to promote a dialogue with Canadians about their health system, build on work already done, identify priorities and help Canadians develop a consensus for changes required. The forum planned for 75 discussion groups in 35 communities. (C.Gray 1996)

Lavis & Anderson (1996) argue that a major focus of the current health care debate is the notion that a substantial proportion of the health care delivered in Canada is inappropriate, both in service and in setting, a problem shared by all OECD countries. They call for the establishment of criteria for appropriate care to enable everyone in the system to be accountable for ensuring that appropriate care is provided in appropriate settings. Terris (1990) outlines other negative features of the Canadian system: failure to monitor the quality of care, and neglect of serious support for preventive services and improved living standards.

The idea of rationing services worries patients (those on waiting lists), politicians (whose constituents are on waiting lists), and medical practitioners, who feel that rationing should be a political problem, not a medical problem. Because additional billing charges are not permitted, it is widely assumed that a high level of
equity has been achieved, with respect to having a progressive redistribution of benefits to individuals and achieving a fairer apportionment of health resources and facilities between regions across Canada. Badgley (1991) argues that this is not the case, and the research record shows that while all Canadians have benefited, there has been little significant change in the disparities in longevity and the prevalence of illness and disabilities between the poor and other Canadians. The social policy initiatives have concentrated on cost containment and ensuring equality of opportunity in access to benefits, rather than seeking to alter those features of the social system serving to perpetuate ingrained inequality. The introduction of national health insurance and its operation over the past two decades have not fundamentally altered the pre-existing inequities shaped by Canada's class structure. (Badgley 1991; Wolfe 1991) This helps to make invisible both poverty, and the features of the social system which prevent the realisation of equal opportunity. Health promotion initiatives emphasise individual responsibilities for altering lifestyles, and

"it is notable that at no time since the introduction of national health insurance [in Canada] has a consolidated official review been undertaken of the issue of class and health, particularly as this pertains to the poor, the disadvantaged, and Indian and Inuit people living in isolated northern communities." (Badgley 1991, p.666)

Badgley raises the fundamental concern about whether a reasonable level of equity in health and access to services can ever be achieved in nations having distinctive regional priorities, a federal structure which bonds together people of different national and cultural backgrounds, plus a sharp gradient of economic opportunities entrenched. However, as Wolfe (1991) notes, Canada has tried to achieve the best of two worlds - public participation in local initiatives on the one hand, and on the
other, attempts of a central authority to achieve reasonable equity through universal entitlement programs - and hasn't done too badly. Having grafted a public payment system onto an essentially private practice system, the Canadian Medicare system is infinitely superior to the situation pertaining south of the border, where 40 million are totally uninsured and another 20 million are underinsured in the face of serious illness.

3.3 United States of America

American politics is schizophrenic about health care.

"On the one hand, in the context of the American debate among policymakers and business community leaders, the paramount issue is cost-containment. On the other hand, the issue for lower-income advocates and for significant sectors of the American political leadership is universal access to the health care system. What is often striking about American politics is the extent to which these two critical aspects of the provision of health care are rarely linked in American public-policy debate." (Francis 1992, p.87)

The USA has a morality problem, rather than an economic problem. Contributing to this is the fact that the USA doesn't have a health care system at all, as that term is understood in other OECD countries. Rather it has a health care industry, composed of federal and state systems, which is now a US$1 trillion a year enterprise with 10 million employees (7% of the work force in America). The interest groups which benefit from the health care industry will not easily give up their power and profit, and Brightbill (1991) has detailed the enormous political clout of such groups with details of political action committees (PACs) and the influence they can buy. In 1990, they gave US$7.7 million to influence politicians in their health care deliberations. When the debate on health care reform was placed on the political agenda in 1991, interest groups increased their donations, spending over $100 million during 1993 and 1994 to influence the outcome of this public
policy issue. (USA Center for Public Integrity 1995) While there is no universal health care coverage, two programs operate to offer publicly funded health care via state administration: Medicaid for the poor and Medicare for the aged, legislated in 1965. (See Iglehart 1983, 1992c, 1993a; OECD 1994a, pp319-320; Quade 1989) State governments have reduced their Medicaid programs to the point that they now cover only between 32% and 36% of citizens classified as poor, down from 65% in the mid-1970s. (Morone, 1990, p.139). Other public programs offer health care to specific groups, such as war veterans, which is a federally administered program. In total, public health care accounts for approximately 40% of the USA's health bill. It has been estimated that the USA will spend 16% of its GNP on health care by 2000 (OECD 1994a, p.321) because there is lack of overall control of expenditure on health care, and the private sector is becoming more and more profit-driven.

There is a cyclical nature to the attempts to provide a national health care system in the USA. [For a history of the 'waves' of attempts see Bauman (1992), Beauchamp (1993) and Richmond & Fein (1995). See also Health Affairs 1995; 14(1), an issue devoted to health reform: past and future, and 14(2), an issue devoted to pursuing reform and managed care.] Although universal health care has not been introduced, Marone (1993b) considers that the last decade has provided incremental reforms which have transformed administrative politics, reshaped the organisation, expectations and distribution of authority in medical policy. The pressure for the latest attempt at universal health insurance stems from two new phenomena: many physicians supported the effort - many medical journals which normally publish only clinical matters devoted large sections of each issue to the
economics and politics of health care reform - and many large industries wanted reform to ease the burden of health care insurance which they must provide for their employees. These two interest groups have, up until now, been seen as impediments to any universal health care system in the USA. These pressures, however, do not stem from ethical concerns about the gross differences in health status between various groups, the lack of access to health care and the fact that people who can't afford to pay for care can't obtain it. Rather, the main interest of medical practitioners was to protect their incomes and their clinical autonomy, and industry wanted to shift the costs of insurance to some other sector. There are many views as to the reasons for both the attempts at health care reform and their dismal outcomes. The economist Feldstein (1992) claims that the objective of a national health system is an attempt by the powerful classes to shift their costs onto others, and can only be understood in these terms. Navarro (1993, 1995a, 1995b), a political scientist, puts the current mess down to class interests, and Dandoy (1992) and Grogan (1995) point to the politics of federalism, arguing that recent federal policy is less a search for comprehensive care than for the mechanisms to avoid the burdens and responsibilities of costs. Jacobs (1994) and Jacobs & Shapiro (1994a & 1994b) point to the role of public opinion. Jacobs (1991) and social policy analysts Immergut (1992), Skocpol (1993, 1994a, 1994b), Maioni (1995) and Steinmo & Watts (1995) all argue that political institutions hold the key to analysis. Ginzberg (1991a) believes the political key to any substantive reform is in the attitudes of the middle class. Blumenthal (1995) takes an historical perspective to analyse the latest failure, and finds interesting parallels between the introduction of Medicare in 1965 and the demise of President Clinton's federal legislation
proposal. One factor cited is the existence of powerful special-interest groups - the American Medical Association in the 1960s corresponding to the Health Insurance Association of America in 1994. Also, American politicians and political institutions were not qualitatively different in 1994 from what they were in 1965. ‘Gridlock’, questionable ethics and eccentricity were at least as typical of the national legislature and legislators in the 1960s as they are today. An important difference between 1965 and 1994, though, is that the political fundamentals of the Medicare situation contrast markedly with today's situation. The uninsured of 1994 constituted a much less cohesive and powerful potential voting bloc than did the elderly (who were the subject of Medicare legislation) in 1965. (Blumenthal 1995, p.466) As Douglass (1995) points out, however, there needs to be a weaving together of many factors in order to understand the situation - significant political events with evolving concerns for under-served populations, public opinion and popular movements, political strategies that have unintended long-term consequences, power shifts from medicine to administration and governmental organisations, and cycles of concern and complacency among everyone involved. Kronick (1994 p.543) notes the fact that emotionally-based arguments in political conflict have led health care financing arguments to approach the level of theological disputes.

With health services provided by a loosely structured delivery system organised at the local level, hospitals can open or close according to community resources, preferences and the dictates of an open market for hospital services. Physicians, the vast majority of whom are in private practice and paid on a fee-for-service basis, are free to establish their practice where they choose. There is no
health planning at the federal level, and state planning efforts vary from none to stringent review of hospital and nursing home construction projects. (OECD 1994a, p.317) The lack of organisation and planning in the USA is reflected in the way in which there is little distinction between generalists and specialists, the absence of clear responsibilities for population-based health care, the uneven flow of patients through the system, complicated and often incomplete remuneration and the paucity of group practice and interdisciplinary teamwork. (Grumbach & Fry, 1993, p.944)

The move towards coordinated care has exacerbated the interference and intrusion into clinical practice - what Epstein (1993, p.1673) terms ‘the hassle factor’. More than 90% of privately insured Americans are now enrolled in either a network-based plan or a more conventional indemnity plan which incorporates utilization-review techniques. Although coordinated care arrangements, such as HMOs, PPOs etc, encourage provision of services within fixed budgets, they may well have difficulty in controlling utilisation in a system whose basic structure continues to reward increased fee-for-service billings: - there is no central control of budgets or all-payer rate-setting as in the other OECD countries. (OECD 1994a, p.326)

The following are specific aspects of the USA health care industry which require correction by any reform attempt.

i) Administration & Costs

Woolhandler et al (1986, 1991, 1993) using nationwide cost data from 6400 hospitals, found that 24.8% of all US hospital costs go towards administrative and billing expenses. Under a Canadian-style government insurance scheme (i.e. single payer), she estimated that US$118 billion could be saved per annum on administrative costs. In 1960 there was one administrator for every 3.17 patients.
Thirty years later the figure was one patient for every 1.43 administrators. (Woolhandler et al 1993) If the non-clinical spending could be trimmed to match Canada's spending, Woolhandler estimated that the US would save $50 billion per year.

ii) Insurance

The issue of health insurance is probably the most important factor in the whole health care debate in the United States. Many are now asking whether the linking of private health insurance to employment can be ethical policy-making. For example, Jecker (1993) examines whether an unjust distribution of jobs spoils justice in the distribution of health insurance, taking as a central example gender inequities in employment and exploring their impact on job-based health insurance. Public health insurance programs serving welfare recipients and the poor (i.e. Medicare & Medicaid) do not compare favourably with private insurance plans. Many of the aged and the indigent, for whom these federal programs are funded, are not eligible for help because of the severe entry parameters.

iii) Physician Supply

There is no accepted approach to forecasting physician requirements.

"Even though the measurement of entrance and exit rates from the profession is a generally accepted approach to forecasting supply, apparently minor disagreements on assumptions create large discrepancies between forecasts over time." (Feil et al. 1993)

iv) Litigation

The USA is a very litigation-conscious society, hence the practice of 'defensive medicine', where all tests available are performed, even when not considered to be clinically necessary, but because the doctor does not want to be accused of not
trying everything in his/her armamentarium. The other side of the coin concerns lack of interventions by doctors because of the fear of law-suits. One area of concern is the low priority accorded to child immunisation. Some physicians were reluctant to administer vaccines because of liability fears. (Reported in *Australian Doctor*, 4 February 1994)

v) Methods of Payment

Payment is usually fee-for-service, and the billing arrangements put a cash value on every clinical decision (more so than in Australia). The American College of Physicians has acknowledged that fee-for-service medicine at its best, offers the finest medical care in the world, but its excesses are a major driver of runaway medical care costs. [Editorial: *Annals of Internal Medicine*, Nov 1993; 119(9):947]

The Clinton Health Security Plan would have accelerated the decline of fee-for-service medicine.

vi) Technology

Advances in technology are generally acknowledged to drive many cost increases, and American medical practice is aggressive in its use of technology. The use of new technology diffuses rapidly, often before any proper trials of its value have been undertaken. (Mechanic 1993, p.11) The hospital sector is stimulated by a competitive entrepreneurial ethos - hospitals must be attractive to physicians in order to obtain patients - resulting in duplication of expensive technologies and introduction of under-utilised specialised units. Hospitals engage in what has been called a 'medical arms race', in which each competes to own state-of-the-art technology. The US has eight times more magnetic resonance imaging machines
(MRIs) per capita, six times more lithotripsy centres and three times more cardiac catheterisation and open heart surgery units than Canada. (OECD 1994a, p322)

vii) Focus on Acute Intervention

In many parts of the US, as in other OECD countries, there is a lack of adequate community based ambulatory care services, so the patient is hospitalised, adding to health care system costs. As President Clinton said:

"This health-care system of ours is badly broken and it is time to fix it. ...... Every American must have the security of comprehensive health benefits that can never be taken away". (Address to Congress Sept 1993, quoted in Braithwaite 1995, p.102)

The President made the restructuring of health care policy a priority when he took office in January 1992. He had campaigned on four promises: to provide health care coverage for all Americans; to slow runaway medical care cost inflation; to minimise governmental intrusion; and to avoid hurt to most special-interest groups.

It should have been obvious to policy analysts that these four objectives were mutually exclusive: in order to provide 100% health care cover, and to slow costs inflation, there would be a need for much government regulation. The health insurance interests groups, and other for-profit businesses would need to be hurt very badly if the other three promises were to come to fruition.

The opportunity for fundamental reform was

"built on growing dissatisfaction with the increasing costs of medical care, the insecurity resulting from basing health care insurance on employment, and the national disgrace of 37 million uninsured Americans. As a result, a new coalition of big business, labor, some elements of the health care professions (including, notably, the American College of Physicians) and the general public clamors for the politicians to 'fix health care'. Of course the consensus on the need to fix it is not matched by consensus on what to fix, much less how to do it." [Editorial: Annals of Internal Medicine, Nov 1993, 119(9): 945-947]
After eight month's solid research by an elite team during 1992/93, the President released his *Health Security Act* on October 27, 1993, which outlined six principles needed to reform the US health care system: security, simplicity, savings, choice, quality and responsibility. Security meant that all citizens would be guaranteed a comprehensive package of benefits over a lifetime. Simplicity meant removing the myriad of forms used by the 1500 insurance companies, substituting them for one standard insurance form. Savings would be made with the introduction of competition between insurers, and that the earlier interventions which would occur with universal cover, would reduce the costs of caring for more serious, previously neglected cases. It is on the principle of savings that opponents attacked the plan, arguing that lowering the amount spent on health care may well lower the quality of that care. The principle of choice would allow patients to continue to choose their own doctor and may change from one insurance company to another even if they have an existing medical condition. The President promised to preserve and enhance the quality of care, and employers would be made responsible for 80% of their employees' health insurance, with the employees being responsible for the remaining 20%. The government would pay the insurance of the unemployed. (see OECD 1994a, p.334. See also *Health Affairs* 1994; 13(1) an issue devoted to the Clinton Plan: pro and con.)

"President Clinton's *Health Security* plan is a distinctively American synthesis. Like universal health insurance in other industrialised countries, it covers a comprehensive set of benefits for all citizens and makes health coverage a right of citizenship. But unlike most systems abroad, it offers consumers the opportunity to choose among private health plans. ... The plan reflects not only the accumulated experience and evidence of recent decades, but also a series of judgments about the kind of reform American needs." (Starr 1993, pp1666,7)
President Clinton's attempts at reform failed - and failed due not to lack of political capacity, but to political capacity which wanted the reforms to fail. (see *The Lancet*; 1996: 347:1316; Blumenthal 1995. For general discussions on the failure of the Clinton proposal see Dukakis 1995; Jacobs 1993; Morone 1995; Navarro 1995a, 1995b; Rockman 1995; Skocpol 1995; Steinmo & Watts 1995) It would appear that there will never be a one-payer system in the USA, and in the meantime, managed care has proliferated as the strategy by which costs can be kept down. What is now a serious worry to observers is the growing evidence of the decline in the quality of care as for-profit institutions, especially, keep down costs to the detriment of the patient. During 1996, complaints began to mount about managed-care organisations' efforts to control costs at the expense of providing care. Many managed-care companies required discharge after only 24 hours, and Congress had to pass measures limiting the power of these companies. (Reported in *The Lancet*, 1996; 347: 1180)

"Since the great build-up to reform the health care system of the USA collapsed under the conceit and dollars of industry lobbyists, Republican saboteurs, and a well-intentioned new President with scant leverage to support an unwieldy plan, little has been done to relieve the burden of uncertainty for US citizens without health insurance. If one listens to the current crop of Presidential candidates, one might think that the problem has gone away. Far from it - the numbers of uninsured people rise daily." (Editorial, *The Lancet*, 1996: 347: 703.)

Health care system reform remains high on the political agenda if only because of the continuing growth in expenditures, and the resulting pressures on federal, state, corporate and individuals budgets. (OECD 1994a, p.336) Unfortunately for the 40 million US citizens without health insurance cover, there is still no universal coverage, and little likelihood of this ever being realised at a federal level. Schroeder's (1993) fear of the worst outcome had been confirmed.
"Perhaps the worst outcome of the forthcoming political debate (on President Clinton's Health Security Act) would be to sacrifice the commitment to universal coverage because of the understandable concerns about costs, the deficit, and the economic vulnerability of small businesses."

One conclusion to be drawn from the four years of intense discussion and debate on health care reform is that the USA has a crisis of morality, for until a universal scheme is introduced, America remains the only country in the OECD, albeit the richest, which does not care enough about its citizens to remove from them the financial hazards of ill-health.

3.4 Australia

By contrast, Australian Medicare has reduced the financial burden that ill health and injury may bring by providing universal health insurance coverage. In 1989 Australia was 11th out of 24 OECD countries in per capita health spending (Schieber & Poullier 1990). As in the other four countries, despite the high level of health status, those in lower socio-economic groups have poorer health and are less likely to use preventive services than other groups. Living in rural areas, being male and being Aboriginal are all associated with poorer health. (Australia. National Health Strategy. Research Paper #1 1992) The present Medicare system, introduced in 1984, is based on five principles: universality, access, equity, efficiency and simplicity. McLeod (1987), however, suggests we should have a single, clear objective: That no Australian resident suffering from sickness or injury should ever be forced to forego care for lack of means to pay. Medicare is administered by the Health Insurance Commission (HIC), which rebates to patients 85% of a scheduled fee for out-of-hospital medical services, and all in-hospital charges for public patients. Private hospital patients often have large bills to pay,
after private health insurance and the Medicare portions have been paid. However, the number of people with private insurance has been falling: from a high of just under 70% at the end of the 1970s to 43.1% in 1990 (Australia, National Health Strategy Background Paper #4) and is projected to fall below 40% by the end of 1996. (Australian Institute of Health & Welfare 1994, p.138) Many medical practitioners ‘bulk-bill’ which means that the invoice-voucher is sent directly to the HIC for payment, and the patient has nothing to pay. The number of bulk-billing practices was 60% in 1990 and increasing. (Stutchbury 1992, p.267) Other practitioners bill the patient who must pay the difference (the ‘co-payment’) between the rebate and the account figure, which may be higher than the ‘scheduled fee’, as laid down by the Medical Benefits Schedule Committee. One of the major problems is that the ‘floor price’ set by the scheduled fee is too low, with the Medical Benefits Schedule of rebates not keeping pace with the consumer price index for many years. This has forced doctors into either seeing more patients than is amenable to keeping high quality standards, or charging higher co-payment fees. Baume (1995), previously a Liberal Senator for NSW (1974-91) and Minister for Aboriginal Affairs, Education & Health (variously, 1980-85), is scathing towards what he views as a total lack of health policy, and echoes Seedhouse's (1994, p.2) accusation that policy-making is lacking a theoretical coherence.

"There has been no health policy from either major Australian political party for many years. What we have had in Australia have been shrill debates, usually at election time, about the financing of hospital and medical care, about insurance programs, about co-payments, about reimbursement, about hospital activity, about the industrial disputes that plague the hospital system. But there has been no discussion of, or debate about health - that is to say, no debate about the health of the people of Australia. Largely because of this, the so-called health debate in Australia has been a disgrace for decades. It is disgraceful that politicians dare to present payment proposals and then to assert that these represent a health policy. They do not - and they never have. It is disgraceful that
the media has not picked up on the poverty of the presentations and called the politicians to account for their failures. It is pathetic that the questions put to politicians concern payment almost all the time and that questions almost never concern health itself. It is pathetic that the Australian public is willing to acquiesce in this deception and, in effect, to become an accomplice in this charade.” (Baume 1995)

**Problems in the System**

Medicare is extremely popular with the public, but it is inequitable in many ways, and has been showing signs of inability to cope for some years. Major problems at macro-level include inequitable allocation of facilities and manpower, inequitable funding of hospitals, and unfair rebate schedules. Australia’s fiscal deficit has caused governments to cut health care budgets, a substantial proportion of which is allocated to the large hospitals in the major cities, leaving the rapidly growing outer areas without adequate health care coverage. Forecasting and planning of the medical workforce in Australia is so inadequate than an insufficiency of GPs in the late 1970s was transformed into a glut by 1989. (Australia, CDH&FS 1996, p.11)

The oversupply of doctors in some areas, notably capital cities, and undersupply in others, notably rural areas, has provoked the current Liberal federal Health Minister to suggest co-option of graduate medical students to work in country towns, and/or to refuse the issue of Medicare provider numbers to graduates. A sore point with many Australian doctors is the intake of foreign medical practitioners, who constituted 23% of the medical workforce billing Medicare in 1994-95. (Australia, CDH&FS 1996, p.39)

At the macro-level, global budgets have kept costs down, but budget cuts have seemingly removed too much of the fat in the hospital sector. Commonwealth-state relations in Australia have been a problem area in health policy, especially in funding matters and the provision of programs. (Ducket & Swerissen 1996; Butler
Attempts have been made over the last decade to rationalise relations to eliminate duplication and improve accountability, the latest being the decision by the Council of Australian Governments (COAG) to re-examine the roles and responsibilities in health, community services and child care. COAG has argued for reforms in specific purpose programs in human services and health to focus on outcomes. (Australian Community Health Association 1995).

Within the public system, emergency patients face the prospect of being driven or flown around certain states in search of high-technology intensive care beds. According to the OECD report (1994a, p.41) on health care system reform, Australia is one of four countries appearing to have the highest ratio of acute-care beds to population, although not among the countries with the highest health expenditure in 1992. With the maldistribution of facilities and manpower, however, it is difficult to tell whether insufficient funding is the case or not. In the eastern area of Sydney, for example there are 10.2 intensive care beds per 100,000 of population, compared with 1.3 such beds in south-western Sydney. However, aged patients may have to wait for quality-of-life-enhancing operations, and many surgery candidates have their operations continually postponed. At the same time, private hospital facilities are underutilised.

At meso level, the medical treatment of public and private patients is generally of the same high quality, but public patients make no co-payments while private patients, who pay the Medicare levy and private insurance premiums are often left with heavy bills which reflect the difference between doctors' charges and the rebate schedule. Policies over the last decade have encouraged people to drop private health insurance, with resultant stress on the public hospital system.
At micro-level, bulk-billing practices are not always spread evenly geographically, so some people pay nothing for personal medical treatment at GPs, family practitioners and other primary care practices where bulk-billing is practiced, while other patients may have high co-payments if their medical practitioner does not bulk-bill. While choice of GP is available, usually people choose a doctor in a convenient location, and some suburbs do not have bulk-billing practices. Waiting lists for many interventions, cancelled operations and long waits to obtain outpatient and emergency care at public hospitals show the strains to the system. (Baume & Wolk 1995; Buchan & Brook 1995) Federal government policies about health care have been dominated by health insurance, an issue which has produced hostility in Australia ever since the introduction of the Earle Page government-sponsored (private) health insurance program in 1953, and the problems which these policies have generated within the medical profession and the state governments. (Palmer 1989, Palmer & Short 1994; Sax 1984, 1989, 1990) Prime Minister Whitlam’s universal national health insurance program ‘Medibank’ was introduced in 1975 after “the bitterest episode in a saga of hostility extending over several decades” (Scotton & MacDonald 1993, p.xi). Australia is contrasted with Canada in this respect. All basic federal legislation underlying Canada’s Medicare program was passed unanimously by Parliament: Canadian Medicare as such has no political opposition. No other Canadian legislation has ever been so treated. (Evans 1992a, p.368)

Changes to the Australian Health Care System

The main changes to Australia’s health care system have involved, at macro level, the allocation of resources within the system, by budget cutting at both federal and
state levels in an attempt to contain costs, and to force the improvement of efficiency and effectiveness of service delivery at meso level. There has been some tinkering at the edges in the case of health insurance. The adoption of the new public management philosophy within the health care arena saw far-reaching management changes, especially within the hospital environment, and in federal and state health departments or commissions. (Braithwaite 1993; Duckett 1991, 1994b) These departments or ministries have been in constant 'reform' mode, which has not improved morale in this workforce. The turmoil in the Health Department of Western Australia is evidenced by the comments in the department's Annual Report by the Commissioner of Health every year since 1984, thanking the staff for their forbearance during "this time of change".

At the micro level, quality improvement departments and programs began to proliferate throughout Australia's health care systems. By 1987, 70% of Australian hospitals were involved in quality assurance activities, involving the Australian Council on Healthcare Standards and their hospital accreditation program. Support for the concept of the measurement of clinical and managerial performance will be a critical future issue. Grant & Lapsley (1992) see performance measurement as 'a dominant theme of the 1990s.' At clinical level, the Australian National Competition Policy (Hilmer) transformed the public from citizen to consumer, with patients viewed by many as customers or clients. (Carver 1996)
Attempts at Reform: Health Care Policy Initiatives

i) DRG/Casemix

Moves towards clinical costing, required with the introduction of DRG/Casemix systems, and information systems based on a patient-focused, final output model, are currently underway in Australian hospitals. (Braithwaite 1993, p.425) While casemix systems of funding are a welcomed replacement for the inefficient and unfair practice of historically-based funding, the management changes are contributing to a trend towards discharging patients more quickly - the 'quicker and sicker' phenomenon. (Duckett & Jackson 1993; Herring 1991; Hindle & Scuteri 1988, 1989; Hindle, Pilla & Scuteri 1991; Hindle, Hanson & Holt, 1992; Horvath 1985; Lee 1996; Reid, Palmer & Aisbett 1991; Shiell 1993; Stoelwinder 1990)

This is a problem in Victoria under the fully-implemented casemix system. The rate for unplanned re-admissions in Victoria rose from 9.3% in September quarter of 1993 to 10.3% in March quarter of 1996. (Reported Weekend Australian Sept 7/8 1996, p.25) It is difficult to know whether the cause of the 'quicker and sicker' syndrome is the implementation of DRG/Casemix, or the effects of the large budget cuts which accompanied the introduction, or probably a mix thereof. All states were to implement DRG/Casemix, but many adopted a wait and see approach. Victoria was the first state to fully implement casemix funding, and the reform of public hospital funding in that state has been reviewed by Duckett (1994). South Australia, Queensland and Western Australia followed. Reform was long overdue, with historically-based budgets rewarding inefficiencies. The reforms introduced a fairer basis for funding hospitals in the context of overall budget reduction, although casemix in Australia has been referred to as "doing a McDonalds". Any patient not
fitting into a DRG was likened to requesting a “McFeast without the cheese”, thus messing up the system. (ABC TV *Four Corners* program, broadcast 16 October 1995) Objectives were to improve the efficiency of public hospitals, and to treat more patients and thus reduce waiting lists. In Victoria a capped budget pool was introduced in late 1994, in contrast with South Australia where implementation of casemix was with an uncapped pool - an incentive for hospitals to blow out activity levels. Casemix, however, relates only to inpatients, and hospitals perform many tasks in other areas, such as outpatients clinics, teaching and research, rehabilitation services, etc., where it is more difficult to build financial/economic models because of their variable time-frames and partly because of the more intangible nature of their outputs.

**ii) National Health Goals and Targets**

In 1986, the Better Health Commission published 3 volumes “Looking Forward to Better Health”, which detailed national health goals and targets. In 1988, the Health For All Committee’s Health Targets and Implementation Committee (HTIC) published “Health For all Australians” which was a Report to the Australian Health Ministers’ Advisory Committee and the Australian Health Ministers’ Conference. Outcome goals were identified, albeit modest and related to relatively low-cost and low-tech issues. $39 million over 3 years was budgeted, but the activities were not internalised into the hospital and medical management systems. Thus the goals remained unmet. A Progress Report (Nutbeam et al 1992) advocated a comprehensive effort for improving the health status of the population rather than attempting to improve the health care system itself. The national goals
were revised in 1993, and were published as "Goals and Targets for Australia's Health in the Year 2000 and Beyond", (Nutbeam et al 1993.)

iii) National Health Strategy (NHS)

In 1990, a review of Medicare was announced with the aim of developing a National Health Strategy. A considerable investment of resources went into the two-year project the objective of which was to refine and improve Australia's health care system. (Australia. National Health Strategy Background Paper #1. 1990) The first issue paper from the NHS was entitled "Australian Health Jigsaw", a title capturing the complexity of a system which comprises state and commonwealth involvement, a multiplicity of health care providers, a complicated mix of private and public services and a bewildering array of technology and clinical strategies designed to improve and maintain the health care status of patients. The NHS identified several inter-related issues as the key pressures confronting the health care system: i) the use of health services is increasing; ii) there are difficulties with access to health services, due to remote location, cultural relevance and other factors, groups such as the chronically ill have less access due to cost factors, and waiting times for admission to some public hospitals is a serious issue; iii) accountability by providers of health care to both consumers and payers needs to be improved; iv) responsibility for financing and delivery of health services, shared by federal, state and local governments, the private sector and individuals, does not necessarily ensure the best type of care and the best use of resources; v) there is a lack of integration of services which means that the best mix of services is not always provided. Choices must be made in balancing the mix of services between curative treatment, primary care, public health and health promotion. The mix of
institutional and community care must also be improved. (Australia. National Health Strategy Background Paper #1, 1990, pp 7-8) Another issue which must be added is the grossly inadequate attention being paid to mental health care, attested by the 3 year inquiry by the Australian Human Rights Commissioner (Burdekin Report 1993). There has been very little in the way of public comment on the results of the National Health Strategy, unlike in the USA, where the proposed health care reforms generated a huge debate. Australia needs to have a public debate—perhaps a National Health Forum such as in Canada—so patients/consumers have the opportunity to help fashion health policy. But, as Braithwaite (1995, p.107) observes,

"public policy in Australia tends to be formulated either by politicians on-the-run or by bureaucrats, policy-makers and providers for the consideration of other bureaucrats, policy-makers and providers. The Australian National Health Strategy is a case in point."

iv) The General Practice Strategy

This strategy developed out of the 1991 discussions held between the AMA, the RACGP and the federal government on the broad themes of workforce and standards, to examine proposals to enhance the status and quality of general practice. (For initiatives Australia. Commonwealth Department of Health & Family Practice 1996, p.xxxii)

v) The 1994 National Health Information Forum (NHIF)

The NHIF was convened by AIHW in November 1994 to recommend strategic directions for the development of national health information in Australia over the next 5 to 10 years. The forum was attended by representatives from all Australian health authorities, non-government organisations, health consumer organisations
and the private sector, academics and other experts in health and health information.

(Fett 1995)

4. Conclusion

Reforms to the health care systems of the five countries have done little to remedy the obvious problems of (ill) health status, having concentrated on the fiscal issues inherent in the financing and provision of care to the detriment of equity, appropriateness of care and quality of care. Clinicians are demoralised and are becoming increasingly marginalised as clinical autonomy is taken away by accountants’ fiat. Patients are having to finance more and more of their own care in those systems were public insurance provides the care, while governments are undermining the incentives for people to take out voluntary insurance. As the twenty-first century approaches, health care systems in these five countries have become mere shadows of their former selves. Economic rationalism has brought an overhaul of the technical efficiencies, but has also eroded any shred of caring and compassion, the tenets of which once underpinned the systems in Australia, NZ, Canada and UK. The emasculation of the health care systems in these countries may yet be the catalyst for the political downfall of the governments in power when people have decided that some public goods require public administration and simply do not belong in the market place.
Chapter 8. CONCLUSION

"Would you tell me, please, which way I ought to go from here", said Alice.
"That depends a good deal on where you want to get to," said the Cat.
(Lewis Carroll: Alice's Adventures in Wonderland, p.64)

After almost two decades of health care system reform, the outcomes in the five countries leave a lot to be desired. At the end of 1996, a survey of finance directors of Trust hospitals and health authorities in the UK showed the NHS to be in its worst cash crisis for years. (The Lancet 348:1507) An Audit Commission Report indicted the GP Fundholding scheme in the biggest study yet of the changes to the NHS. The Commission reported a huge increase in administrative costs and poor practice in assessing the needs of the population, patients' wishes and local health priorities. (The Lancet 348: 1727) Kenneth Calman, the UK's Chief Medical Officer has seen "an unprecedented level of inequality" which continues to worsen with effects on all health outcomes. Trevor Sheldon, from the NHS's Centre for Reviews and Dissemination found that social and fiscal policies have failed to protect the poor. (The Lancet 349:708) The NHS is underfunded to the point of collapse, and political ideology and the myth of the NHS's quality are stopping the rational solution of means-testing and infusing the moribund body with the life-force of private funding. While New Zealand doesn't have the problems associated with a large population like the UK, nor the squeamishness about private finance, the reforms there have resulted in inequities if not on such a large scale. The latest administrative strategy involves patients being awarded 'points' in a system where those with the most points obtain treatment, others go on a waiting list. At the beginning of 1997, 770 people out of 4650 on waiting lists were told that they
didn’t have enough points to warrant treatment - that is, they would have to wait until their condition worsened so that they would obtain more ‘points’. Even so, the score needed to obtain a booking is often determined by the amount of funds available and not by medical need. Extra points are given if the individual patient is judged to be a ‘productive member of society’, such as being in paid employment or is caring for children. *(The Lancet 349:862)* Canadians have appeared to fare much better than their cousins, but their reforms have not been as radical as those in the UK and NZ. The National Forum on Health in its final report *Canada Health Action: Building on the Legacy* concluded that there is no Canadian Medicare crisis because of government underfunding. The Forum suggests that the solution to the problems lies in better management and an expansion of benefits to include coverage of home care and prescription drugs. The Forum decided that Canadians are paying more than enough each year for health care, and the panel argued that profit-driven health care is costly and inequitable. *(The Lancet 349:482)* In Australia, the Medicare system for primary care is deemed to be using too much of the health care budget, although there has been no public discussion on how much is enough, or too much or too little of taxpayers’ money to be spent on health care. The federal minister for health decided that he would solve this problem, and the problem of too few doctors in rural areas by arbitrarily refusing to issue health care provider numbers to any medical student graduating after January 1997, unless they agreed to work in the wilderness of rural areas. If politicians and bureaucrats won’t question such inequitable and unintelligent decision-making then the public must demand a voice. Approximately 10,000 medical students had their careers and their lives, not to mention their families’ lives, permanently altered by the resultant
legislation. It is the health care providers rather than patients who are being treated inequitably in Australia, which simply continues the trend for it is the health care providers who have been subsidising public health care for decades. Political ideology in this country also is contributing to the demise of once excellent health care system as the federal government has removed the tax incentive for people to purchase voluntary health care insurance cover. The result is an overburdened public hospital system, clogged with patients who can well afford health insurance, but refuse, logically, to buy it as the government provides 'free' treatment.

These four countries have had health care systems funded by taxation or levies and have been judged to have provided fair average quality health care systems in the past. In each case, however, their systems in the latter half of the 1990s are falling apart. Yet these systems are far more equitable (and cheaper) and provide better health outcomes on the whole than does the USA where at least 40 million people are without medical insurance cover, which means no treatment at all, or recourse to second-rate public health care. After the fiasco of President Clinton's attempt at health care system reform, the best that the US Senate Democrats could suggest was to make their top priority for the new Congress the provision of health insurance coverage to the estimated 10.5 million uninsured children.

These results beg the question - where were the policy makers trying to get to? Not even the most hardened cynic would suggest that these are the results the policy makers were wanting or expecting. These results have occurred largely because policy makers expected the market mechanisms to work in an area where they were never intended to operate. The market can't assign values, it can't make
judgments on social and political problems, and it can’t enforce political will. The lack of attention to these factors by policy makers has exacerbated the ills of the health care systems. Nor have the policy makers any excuse for not knowing where they were going, as the literature is replete with warnings about the consequences of this ignorance. Weale’s check lists for resource allocation, for example, provide the questions policy makers ought to be asking themselves. (see Chapter 5 above)

This information was published by the King Edward’s Hospital Fund for London in 1988. The most important warnings about the reliance of policy makers on economic theories have come from economists themselves. Does political pragmatism outweigh the importance of research findings, or are policy makers either ignorant of or blind to them?

The following comments from the editor of an influential journal and two respected health economists reinforce the need for care to be taken in applying concepts from economic theories in the hope of obtaining reforms to health care systems.

"In the case of health care reform, countries often request health economists to advise about the necessary changes or reforms that may improve the performance of a system in terms of equity and efficiency. No doubt they do a good job at pointing to the peculiar mechanisms in health care that need to be taken into account when trying to improve the performance of a health care system. Despite three decades of health economics, there is still little evidence to suggest which model is to be preferred in what circumstances, and there are few rigorous comparative studies of health care systems.” (Editorial Social Science & Medicine 1994 38(1): vii-viii.)

"...Although the prism of standard neoclassical economics can highlight a good many of the relationships among actors in the health care sector, our profession’s valiant attempt to force all of the health care process onto the Procrustean bed of that theory actually runs the risk of professional malpractice.” (Reinhardt 1989)

And as the moderating voice of Fuchs (1993, p.16) suggests:
"Neither in health care nor in any other area can we achieve all the efficiency, justice, freedom and security that we would like to have. Economics can help us understand the trade-offs that we face, but only a commitment to resolving our political and social dilemmas can release us from our present impasse. What is desperately needed is for philosophically opposed groups to recognise that there is some merit in each other's point of view, and to affirm the importance of both individual and collective responsibility in the creation of the good society."

Perhaps it is time for policy makers to understand the place of health care in society, to get back to basics and start viewing the whole forest and not just the few trees which are presently occupying all their attention.

Establishing a Fundamental Theory

Health economics is growing as an industry and as an academic pursuit. In 1995, the International Health Economics Association, based in the USA, was established with an aim to be a focal point for health economics around the globe. Its initial membership base was 500 economists from 28 countries. New journals are appearing, disappointingly intent on mathematically modelling problems which are social and political and which require more qualitative research. Even more alarming is the trend to international corroboration of theories, using the same questionable assumptions, and concentrating on the measurement of benefits, using the concepts of QALYs and HYEs (healthy year equivalents), and such issues as willingness to pay and conjoint analysis. (See The Lancet 1995; 346 (Suppl):10)

Health care economists need to work towards a more fundamental economic theory of health care, particularly the distinction between the concept of 'demand' and the more nebulous concept of 'need'. Demand is determined by a person's individual desires and their ability to pay. Many societies, however, have decided that the ability to pay should not be a criterion for access to health care, and have instituted
insurance schemes, both public and private, to community as a whole. The concept of patient-as-consumer, with the attendant economic assumptions, falls down when it is realised that the patient authorises the medical practitioner to act as his/her agent for decision-making, because the consumer-as-patient does not have the information on which to base decision-making by herself. Rather than being seen as ‘consumers’, patients should be helped to evolve as ‘co-producers in continuing relationships’. Tudor Hart (1992) points out that it is now recognised that patients supply 85% of the information required for diagnosis, and their participation and understanding are essential for the management of an illness. The quality of the relationship between patient and doctor profoundly affects compliance, dropout rates, investigation rates and willingness to ‘wait and see’, hospital emergency admission rates and average length of stay. Any move to consumerism has the potential to have detrimental effects on the quality of patient care. No matter how much consumer groups would like to have patients making their own treatment decisions, and at the same time lessening what they see as medical ‘power’, or ‘paternalism’, the fact remains that the medical practitioner must continue to be the final arbiter of ‘need’. In the case of managed care in the USA, there are problems occurring with the financial administrators of the managed care facility (e.g. an HMO or similar) dictating to the clinician the preferred treatment, or worse, whether or not any treatment will be permitted (i.e. paid for by the facility’s insurer). As an example, the *New England Journal of Medicine* 17 Feb 1994 reports the case of a doctor employed by a health fund in the USA, who relates a day in his life, helping administrators to decide who could have treatments and who could not. Among the treatments being considered were those costing
$200,000 to $1.3 million each. One example given of 'wasted' resources concerned a patient who had been treated at a cost to the health fund of $300,000, and had lived only 30 days after having the operation - an outcome which was probably foreseeable. Input from people other than accountants is essential to this process fraught with moral dangers.

Reforms as Future Problems?

The reforms are based on 'economic rationalism' with the attendant assumptions that human behaviour is primarily economically driven, and the health care market might be not too dissimilar to other types of markets. This led to the diagnosis of inefficiency and a prescription for competition. But the rational choice approach is showing its limits. There needs to be more emphasis in social policy on developing a better understanding of the way in which individuals take their decisions, as argued by Klein & Millar (1995), and acknowledging the context of public policy within which they act and the interaction between the two. The reality of the situation is much more complex, indeed messy, than the economist's simple model portrays. For the USA in particular,

"American health care is a product of the ubiquitous, entrenched view that market-place economics yields efficiency through competitive pressure. To a considerable degree it is business- and profit-oriented. In this respect, it is at odds with western economies that deliver the majority of health-care services utilising taxpayers' dollars, imposing financial ceilings and regulation to dampen expansionary tendencies. The US has permitted the proliferation of vast numbers of plans, devised primarily by insurance companies and self-insuring employers, to provide funds to pay for these costs. Other countries have a much cheaper single-payer system or limit national health-care expenditure through policy measures."

(Braithwaite 1995, p.103)

The providers of health care, most notably the medical profession, have been urged by politically-minded colleagues to take an interest in understanding the intricacies
of their complex, patchwork health care system. Jerome Kassirer, Editor-in-Chief of the New England Journal of Medicine stated the case:

"In previous decades the intricacies of the American health care system were largely irrelevant to a physician's day-to-day work and were easy to ignore. But not today. The progressive decline in doctors' independence and public esteem, the increasing burden of utilisation review and paperwork, and the frustration of trying to provide care to uninsured patients are daily reminders of the chaotic structure and function of our system. Despite the large numbers of health care plans proposed this election year, it seems virtually certain that none will succeed in dealing effectively with uncontrolled costs, inadequate access and dispirited physicians." (Kassirer 1992, p945)

The public has a deep distrust of 'big government', a long-established American political value, as well as a belief that the private sector is inherently more efficient than government. (Jacobs 1993) In the case of the health care industry, however, this belief is tempered by distrust of the health insurance industry. (Blendon et al 1994, p.284) In the USA the money that finances health care flows through third parties, approximately 1500 insurance companies, a situation which gives neither patients nor providers incentives to lessen their usage of health care services. Each insurer has different forms and regulations, so patients and providers have to spend administrative time filling in a confusing array of forms, making for a very expensive way of managing the financing of health care. Terris (1990) found that multiple insurers use 5.6% of the health dollar in administration costs. It has been suggested that many insurance companies now use the intricacies of this paperwork to either delay legitimate claims or refuse them altogether.

"Reformers seeking solutions to contemporary policy dilemmas are generally bound by these parameters of American government: the faith in impersonal gimmicks, an ascetic's stance towards public administration, a penchant for implicit solutions, a marked preference for respectable clients, and the difficulties of negotiating programs through an intricate political stalemate. These tendencies have shaped past programs, constrain current possibilities, and are likely to characterise the politics that face future proposals." Morone (1990, p.135)
The difference between the American system and others can be summed up by quoting James Morone (1990), when speaking about the Canadian system where politicians must explicitly decide on the funding levels for health care and all other programs (as in Australia):

"It is difficult to imagine a lesson that is more foreign to the American experience. Instead of hard conscious choices, we have sought painless automatic solutions. Rather than explicit programmatic decisions, Americans prefer hidden, implicit policies. Rather than centralise control in government hands, we would scatter it across many players." (Quoted in Rice 1992 pp54-55)

Given the fiscal restraints applying to health care systems, irrespective of perceived need, it would appear that macro policies - such as the employment of global budgets, single-payer systems and funding by general tax revenue and special levies - have probably given policy-makers all the macro-efficiency available, so that there is a need to move to micro politics and organisational behaviour and the inter-organisational networking for future reforms. Micro-efficiencies are to be obtained by the judicious use of interventions, so that ineffective therapies are no longer available, and the use of institutional management practices more amenable to special organisations like hospitals and health care centres. The use of tenets of new public management need careful investigation and analysis to alert managers to unintended consequences likely to emerge if they are mindlessly used. Due regard to equity, accountability and due process must be made. There is irony in the fact that the theoretical base of writing on quasi-markets derives from a standard microeconomics or transaction costs perspective which claims to be more open to organisation theory. But without added qualitative research, this neglects factors such as power, ideology and culture. (Ferlie 1994) At the meso- and micro- levels of policy-making, there is a need to incorporate into the system long-term informal
care i.e. aged care, chronic care and mental health care. The need for such care, and its funding in a mixed economy, must be acknowledged and encouraged and brought into the public policy arena. (Chappell 1993, p.492)

Leading biomedical researchers agree that the greatest advances in health in the near future will come not from their work but from healthier lifestyles and environment - which is under the control of individuals, not health care systems. Whatever system of health care delivery and finance is adopted, purchasers need improved information about costs and effects of competing procedures. (Maynard & Hutton 1992) Pressures for accountability measures and the emphasis on consumerism has led to an increasing number of poorly designed ‘patient satisfaction’ surveys. Most countries have also moved towards more consumer involvement, although this appears to be no more than rhetoric at present. (Carr-Hill 1994a)

Lessons Learned?

Sen (1993) has argued that the true wealth of a community is best measured by the health status of its population, rather than by financial measures such as GNP. The Editor of the British Medical Journal has stated:

"What matters in determining mortality and health in a society is less the overall wealth of that society and more how evenly wealth is distributed. The more equally wealth is distributed the better the health of that society." (British Medical Journal 1996; 312: preface)

If these ideas are true, then the economic measures taken by most OECD countries have not only not helped attain better health status, they have actively increased inequalities while increasing overall wealth. If health status is the criterion by which to judge reforms born of economic rationalism, then the reforms have not worked.
Governments must start to acknowledge the interaction of economic policies, and the effect they have on inequality and health status. The lower socioeconomic percentiles show greater psychological depression as well as greater ill health generally. It is no use reforming health care policy without paying attention to health policy. If cause of ill health is lack of life opportunities (e.g. unemployment), then no amount of reform to the organisation of health care services provision will help attain better overall health status of the population. No matter how efficient a health care service becomes, there will be ever increasing numbers of patients coming through the system.

The need for the re-orientation of health care systems to focus on health gain has been acknowledged by the Australian National Health Strategy, which concluded that “it is important to shift the emphasis from funding and providing health services and institutions to providing care that improves health.” (Australia. National Health Strategy Background Paper #8) How much notice government will pay to the findings of the National Health Strategy is another matter, and the medical profession has disregarded both the necessity for the undertaking in the first place, and the outcomes. The general public appears to be oblivious to the work of the Strategy, and there is currently no forum for discussion of the future of Australia’s health care system.

An Emerging Paradigm?

Klein (1995 p.299) asserts that

"health care reform has been one of the worldwide epidemics of the 1990s, .... driven by much the same set of concerns and ideas that shaped the international vocabulary of debate."

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Economic rationalism was the vector in each of the countries under review, and the disease took hold in health care systems which were under stress from both similar and different reasons. Chernichovsky (1995) sees an emerging paradigm within the reform strategies of industrialised democracies in their search for solutions to the stresses and strains of their health care systems: the provision of equitable, efficient and consumer-oriented health care systems. The paradigm is based on the fundamental principle that citizens have the right to a socially guaranteed package of care, and offers technocratic rather than ideological solutions. It promotes efficiency and consumer satisfaction, with a combination of strategies to combine the advantages of public systems - equity and macro efficiency - with those of the private/competitive systems - consumer satisfaction and micro-efficiency in the provision of health care.

Given that the proposed and implemented reforms differ according to their cultural, social, historical and political circumstances, and that each country will have advantages and disadvantages afforded by their existing institutions and political realities, nevertheless the economic and organisational issues are everywhere the same. The questions posed are how to contain costs, increase efficiency, satisfy consumers and providers, achieve equity and improve the quality of health care, and the principles guiding the solutions are also common to all. Finance is increasingly public and the provision of care is increasingly based on competition. It would appear that 23 out of the 24 OECD countries (USA excepted) have accepted that funding of health care systems should be mainly by public means, with the public/private mix being adjusted according to various
factors and contingent upon the economic environment within a specific country. (Carr-Hill 1994a)

The difference between the old and new paradigms is the requirement for an internal market in the new paradigm, because separate principles (public versus competition) guide each function. In the old paradigm, all functions could be combined institutionally, based on the same principle, being either market or public. In systems which combine the first and second functions, e.g. Canada, the U.K. and the ‘public’ Medicare and Medicaid systems of the USA, the providers of care are reimbursed by the public administrations which organise and manage the system. In systems which combine the second and third functions, institutions organise and manage care for consumers while providing the care as well - e.g. HMOs, PPOs, or health care insurance funds.

Conclusion

If politics is about who gets what, when and how (Lasswell 1936), then medicine and health care is politics writ large. As Maynard & Bloor (1995, p.249) observe:

"[T]he health care policy debate appears to involve the often deliberate confusion of objectives and ideologies by politicians gathering votes in the political market place. This is an essential part of the democratic system, although it does not facilitate clear thinking or logical decision making. Furthermore, it usually alienates the government from the academic research community."

Health care policy is all about balancing needs and resources, and in the final years of this century, the major requirement is to ensure that enough flexibility is maintained so that re-balancing can take place within a rapidly changing environment. There is one point on which all players appear to be in agreement: not only will the future be different from the past, as always, but it will be so in ways that are extraordinarily difficult to predict. (Klein 1995) Technological innovation
will change the face of medicine, electronic networking will allow information to flow to anyone who wants it (and has the monetary resources to obtain it), and the configuration of health care facilities will change with much more provision of care occurring outside hospitals. The clinical environment is also changing, with medical practitioners finding themselves in the role of double agent, i.e. having to act in the best interests of both their individual patients and society in total. This may well result in an escalation of the degree of conflict of interest with which most practitioners have to come to terms. Asking clinicians to take a population focus rather than an individual patient focus is probably expecting too much, given the existing system structure, and is therefore indicative of changes required in the future.

In the final analysis, the problems associated with health care provision are of a political nature, involving value systems, culture and morality rather than economics. For example, if the re-focussing of health care systems away from the funding and provision of health care and towards improved health status of the population and improved health outcomes for individual patients does take place, then the health outcomes initiative must be taken as a serious challenge to the planning, management and evaluation of health services. (Hall 1996) The appropriate measures of outcomes will reflect the values attached to different states of ‘wellness’ and ‘quality-of-life’ by individuals and populations. This raises questions of equity, such as access to health care, and will require very clear equity objectives. Discussions of moral philosophy are more germane to this question than are theories of economics. So far, the economists have held centre stage on this issue with their theories of QALYs, HYEs and utility analyses, but there is little
consensus about the validity of such quality and utility measures, the methods of measurement and the evaluation of results. By concentrating on the economic, health care reformers are bypassing the important questions and can only hope to provide economic answers. The resultant solutions very often are not of the right kind, and will not provide the right solutions to questions of equity, quality and accountability. The reforms of the past have created some of today's problems, and we need to heed Wildavsky's words:

"The reforms of the past lay like benign booby traps which could make one stumble, even if they did not explode. Yet all this had been set up for reasons that once seemed good. ... More and more public policy is about coping with consequences of past policies and less and less about events in society. ... Past solutions, if they are large enough, turn into future problems." (Wildavsky 1979, p.4)

All the evidence points to the fact that these words already apply to the concepts of funder-provider split, GP fundholding, managed care and many of the other strategies now being put in place by 'reforms' to health care systems. As Wildavsky advises, don't think permanent solutions, rather think permanent problems, in the sense that one problem always supersedes another. In similar vein, Neustadt & May (1986, p.106) recommend using the Goldberg rule of never asking 'What is the problem?', but 'Tell me the story!', so that one can find out what the problem really is. Neustadt & May's thesis of thinking in time-lines, that is making use of history, is to be recommended for health care policy-makers. There are three components to this strategy (Neustadt & May 1986, p.251). The first is the recognition that the future has nowhere to come from but the past, therefore the past has predictive value. The second element is recognition that what matters for the future in the present is departures from the past, - alterations, changes - which
prospectively or actually divert familiar flows from accustomed channels, which affects the predictive value and much else besides. The third factor is continuous comparison, an almost constant oscillation from present to past and back, mindful of prospective change, concerned to expedite, limit, guide, counter, or accept it as the fruits of such comparison suggest. Forester (1993 and in Fischer & Forester 1993) also recommends the use of practical judgments learnt from past experiences, echoing Schon's (1983, 1987) thesis of the reflective practitioner. On a comparative note, Evans (1986) points out that by examining others' experiences, one can extend one's own range of perceptions of what is possible. Wilsford (1992) also argues that policy-makers should be seeking out the experience of others, systematically searching for plausible solutions and alternatives, and in so doing, saving the expense of reinventing the wheel. Wilsford's comments were in relation to his observation that US policy makers have always been characterised by a rather self-satisfied faith in the individual and the market as the prime movers of innovation, efficiency and justice, attributes which have not helped to achieve the goals of health care reform in that country.

In public policy terms, Lindblom's (1959) 'muddling through' is the model operative in the health care arena, and while 'still muddling, not yet through' (Lindblom 1979), it is probably more valid to extend Lindblom's thesis and describe the process of health care policy-making as one of 'forever muddling, never through'.

"I don't much care where ————", said Alice.
"Then it doesn't matter which way you go", said the Cat.
"————— so long as I get somewhere", Alice added as an explanation.
"Oh, you're sure to do that", said the Cat, "if you only walk long enough."

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Continual reform to health care systems has gone on for two decades, and has indeed got us *somewhere*. But clearly it is not where many of us would want or hope to be. Nor will the current adherence to the concepts of managed care and all the associated business-related strategies improve this situation, for these are concepts committed to the accountant's bottom line, not to the health needs of the community. It is surely time that the decision-makers in health care policy *cared* about where they were taking those systems. It is time to decide on objectives which will determine which way we go from here. Health care policy decisions must be based on compassion, caring and scientific knowledge and not on concepts which sustain injustice and inequities such as those strategies resulting from economic rationalism. It is time to be explicit about the value judgments underpinning policy goals, and it is time to ensure that the choices made between structures and outcomes be informed by evidence of, and well-founded argument for, the necessity to place health care needs ahead of simplistic economic shibboleths.


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