

Addressing the Minister

Restoring Reality

Editor's Introduction

Health Care Analysis carries an occasional series in which extracts from speeches and other publications of Health Ministers are examined critically. The writings of politicians are not academic treatises, *HCA* does not analyse them in this rarefied light, and it is well-known that

politicians do not always mean what they say. However, where politicians purport to make serious statements, they must expect to be taken at their word.

Readers are welcome to submit relevant material from any of the world's Health Ministers, and may, if they wish, submit analyses of that material for consideration for publication.

Extracts from an Address by the Former Minister for Crown Health Enterprises* to the Auckland Divisional Conference of the New Zealand National Party. 25 June 1995 Debunking the Myths and Restoring Reality

Paul East

After reading their morning newspaper two Thursdays ago, a large number of New Zealanders—more specifically the 250 000 readers of the *New Zealand Herald*—could have been excused for thinking they had woken up in another country!

For there—on page 19—was a story about our public hospitals and a survey carried out by the

Consumer magazine. The survey's overall conclusion, according to the *Herald*, was:

'Most people are happy with their experience of public health and hold the public health service in high regard'.

Similar levels of satisfaction with the services from our publicly-funded hospitals are reflected in customer satisfaction surveys carried out by each of our 23 Crown Health Enterprises.

By and large, those 500 000 people who are admitted to hospital every year are satisfied with the performance of their public hospitals. Yet the wider New Zealand public are assailed by unsubstantiated claptrap from every conceivable interest group suggesting that New Zealand's public health system is falling apart.

That is having an unwarranted impact on public confidence in the system. That's why the *Consumer* survey found that the proportion of people with some level of medical insurance had risen and that those people gave restructuring of the public health system as one of the main reasons for taking out medical insurance.

The *reality* of the public health service is reflected by those who have actually used it.

*A Crown Health Enterprise (CHE) is a hospital, or a group of hospitals and other clinical services. A CHE is the equivalent of a UK NHS Trust, providing services that are 'purchased' by officially separate Health Authorities.

The *mythology* of the public health service is created by those with particular agendas—political, professional and industrial—and disseminated by a largely uncritical media.

I want to debunk ten of the most visible of those myths and replace them with facts. Facts which will allow all New Zealanders to make up their own minds about public health in this country.

Myth One: The Government is Cutting Back on Funding for Public Health

Fact: For the 1992/93 year, Vote Health—the money allocated to funding the public health system—was \$4.06 billion. For the 1994/95 year, it will be \$4.9 billion—an increase of around 18%.

Myth Two: Public Hospitals are Doing Less

Fact: Public hospitals are doing more. For each of the past two years, total services provided by public hospitals increased by around 4%.

Myth Three: When They Run Out of Money, Hospitals Stop Doing All Surgery

Fact: The Regional Health Authorities—the government agencies that provide most of the public hospitals' revenue—have a contract with the hospital (sic) to perform a set number of non-urgent—or elective—operations in any one year. This helps the RHAs direct their funds in the areas of most need. Sometimes, this results in hospitals doing no more of a particular elective procedure when they have fulfilled their contract...

If you need immediate and urgent hospital care at any time of the day or night, it will be there available (sic) to you at a public hospital from a workforce of skilled and dedicated health professionals.

Myth Four: Waiting Lists for all Non-Urgent—or Elective—Surgery is Growing Longer Every Day and those Lists would Disappear if only the Government Put More Money into the System

Fact: It is a fundamental precept of economics that resources—whether they be hydro power or health services—are scarce in that demand for those resources always outstrips the ability to provide them, particularly if there are no price signals. So there will always be a demand for particular health services—no matter how much money and/or resources are provided—and that demand will be reflected in waiting times, or lists. Furthermore, medical advances, instead of reducing those lists, often increases (sic) them. For example, coronary artery surgery was once very risky, and once not even available. Now, thanks to increased skills and technology the risks have reduced and this, coupled with the demand generated by an ageing population, means more people want the procedure...

There are four main reasons why waiting lists are not a useful measure of a hospital's effectiveness.

The first is that it's not the length of the list, but the time you have to wait that's important. A big list does not necessarily mean a long wait if the procedure is quick. Similarly, a short list for a complex, high risk procedure—such as transplants—does not necessarily mean a short wait for the operation. That's why it is more useful to talk about waiting times...

Secondly, there are names that shouldn't be on the list in the first place. The *Consumer* reports that the Central Regional Health Authority has found that the waiting lists in its region could be overstated by up to a third...

Thirdly, it appears a number of people are waiting for inappropriate treatment. For example, there is a wide range of intervention rates across the country for a number of elective procedures with no identifiable clinical reason to explain the different levels.

Finally, there are mixed incentives for specialists, who work in both the public and private sector, to shorten the public list, because any increase in activity in the public sector clearly will have an impact on their private sector activities.

Myth Five: If I'm Old, Sick and Need Expensive Medical or Surgical Care, I Won't Get it Because There's Not Enough Money and Younger People Always Get Treated First

Fact: Your age in itself is immaterial, except as an indication to clinicians of risk of complications, the response to the healing process, and the benefits or adverse impacts in terms of the length of your lifespan. Most often, there will be a tick against those points and the treatment will proceed. However, if there is a high risk of complications setting in after treatment, the healing process will be slow and painful, or if it is decided your quality of life won't be improved over a meaningful time span—and clearly the older you are the shorter that time span will be—then the resources that would have been devoted to you will go to someone else.

It's called rationing and it is a fact of life when you are dealing with a finite—or scarce—resource or service. There will never be enough financial resources or skilled personnel to perfectly match demand—that's why choices have to be made. However, the Advisory Committee on Health and Disability Services is looking to establish some sort of priority criteria so these important decisions are made on a reasonably consistent basis throughout New Zealand.

But, at the end of the day, clinicians have an ethical obligation to make decisions—based on clinical priorities—to ensure the most effective use of resources.

Myth Six: Hospital Managers Get Paid Too Much

Fact: The salaries of senior managers in the public health sector reflect the size of the institution they are expected to manage. Generally, these salaries are lower than what those people could expect to earn in the private sector and in the same league as local government salaries which don't draw the same criticism as often.

I ask the question: should these people pay for the privilege of working in the public health sector by accepting lower salaries?

Senior managers don't have jobs for life. They are on contracts which detail what is expected

of them and contain sanctions—including dismissal—if they fail to perform.

Myth Seven: The Country's Public Hospitals are in Deep Financial Trouble and if They Don't Pull Out, the Government will Close Them Down

Fact: Many of the country's 125 hospitals within the 23 Crown Health Enterprises are running at a loss and carrying large deficits supported by money borrowed from the crown and/or the private sector. A loss occurs when it costs more than it should to efficiently provide those services, or the hospital provides more services than it is contracted for.

The government has a number of choices in front of it to deal with those Crown Health Enterprises. It can help them manage their resources better, it can provide them with finance, the RHAs can sometimes increase the CHE's revenue, or the government can dismiss the CHE Board. The government is not about to physically shut down Crown Health Enterprises because they are not financially viable. Finally, it should be noted that this government is addressing the problems arising from decades of disinvestment in the country's public hospitals.

Myth Eight: Every Time Something Goes Wrong in a Hospital it's the Fault of the Health Reforms

Fact: This is nonsense. Like everybody, doctors and nurses and hospital managers sometimes make mistakes—the wrong diagnosis, inappropriate treatment and discharge, mixing up medical records. But on any one day when something goes wrong, there are around 2,100 instances where everything goes right, because that's how many people get admitted to our hospitals every day. Mistakes have happened in the past, happen now and they will happen in the future, that's regardless of what the structure is. The challenge for doctors and nurses is to work together to make sure there are as few of these incidents as possible ...

Myth Nine: The Public Health System is Only About Money. It's Not About People

Fact: If the public health system was only about money, the government would have wasted little time in privatising it. The fact is this government has made a significant investment to improve and restructure the system—often in the face of hostile agendas from sector interest groups—in order to improve service delivery to meet the needs of future generations.

Myth Ten: The Public Health Sector is all About Public Hospitals

Fact: The government spends around \$2.3 billion in providing care for people in public hospitals. That's just over 50% of Vote Health. The other 50% goes on the following activities in the area of what we call primary and community care: GP services, laboratory tests, pharmaceuticals, rest home care and so on ...

I'd ask **Crown Health Enterprises** to plan for smaller hospitals and more community-based services. The 'bricks and mortar' should match the services; not the services being determined by the size of the 'bricks and mortar'! I'd ask them not to exploit their community constituency by using public pressure in their efforts to use increased revenue for an increased amount of hospital-based services from the Regional Health Authorities in order to balance their books. I'd rather they focused on a reconfiguration of services and other efficiencies to ensure they are not losing money, using every taxpayer dollar to the maximum benefit of their patients.

To those who ask why public hospitals should be expected to operate in a businesslike fashion, I say why not? We expect every state agency, regardless of the goods or services it provides, to be well-managed and accountable for the prudent use of all its resources. Publicly owned hospitals are no exception.

I would ask **Regional Health Authorities** to take a more active role in making sure the public understands that they are responsible for the

purchase of publicly-funded health and disability services in their regions.

It is the Regional Health Authority that makes the decisions on the level of health services to be purchased for a community.

I would ask that their purchasing strategy reflects the trend away from hospital to community care; and that a wide range of providers will be (sic) contracted to provide those services.

I would ask of **myself and my cabinet colleagues** to resist the temptation to meddle. Considering the political sensitivity of health, it's a hard temptation to resist. But the restructuring was based on the premise that history has shown that politicians—be they local or national—don't make the best health decisions on their own. We need to let the sector get on with it.

I would ask **the public** to separate the ability of the publicly-funded health and disability sector to deliver quality services from the 'noise' surrounding the debate about the new structures. I would remind the public that we have one of the best public health systems in the world—delivering quality services at a reasonable cost. The facts are there for all to see:

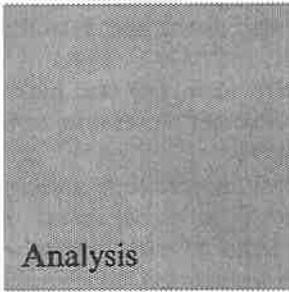
- At 75.8 years, our life expectancy is among the highest in the world;
- At 7.1 infant deaths per thousand live births, infant mortality rates are among the lowest in the world;
- Ministry of Health surveys report 90% of New Zealanders believe their health is 'good' or 'excellent'; and
- At 7.6% of GDP, our spending on health is comparable with countries like the UK, Sweden and Denmark ...

Finally, those opposed to this government's bold measures to design a health service for the 21st century also have a role.

By all means debate the issues with vigour, but don't undermine the public's confidence in the sector's ability to help them when they are in need.

Paul East

Minister for Crown Health Enterprises,
New Zealand



The Commentaries

Uncovering Some Assumptions

Brian Martin and Glenn Mitchell

Paul East's speech is, at the most obvious level, an attempt to defend the New Zealand government's health policies. It addresses a series of alleged 'myths' about public health services, answering each one with figures and arguments. Needless to say, some of these defences themselves could be and have been criticised. The Minister says that he invites a debate, but this seems to be only a rhetorical claim. Nowhere in the speech does he set out the procedure for a debate, nor the social values that might be subject to dispute, nor the constituencies that would be involved.

Whether the speech is interpreted as a defence of policy or as part of a dialogue, there is more insight to be gained by examining what is not said and by exposing the assumptions which underlie it. The basic framework it puts forward is essentially the economically rational allocation of medical services to people in need, within the constraints of finance and the limits to flexibility in the mode of delivery. The assumed institutional structure is community, regional and central health facilities. The assumed goal is equal service to the entire population, at as high a quality as possible within constraints. Within the framework, the Minister's case is entirely logical, even if the 'facts' and his conclusions may be disputed. However the framework of rational allocation of resources provided by health professionals has its own blind spots. In order to highlight these, it is worth looking at the issues from alternative perspectives.

What About The Inequities ...?

The speech contains no mention of any inequities that might occur. For example there is no

discussion of gender, ethnic or class issues. But there can clearly be unequal needs and/or demands for health care due to systematic discrimination, stereotyping, and variations in material conditions. Thus the system may be rational on its own terms while tolerating, perpetuating or even aggravating social inequalities that are linked to health outcomes. While the Minister admits that the government has identified funding variations in the North and South Islands which it is addressing 'through its move to equity', this may not be the health system's only inequity. If 'an increasing range of home based services' and the growth of smaller hospitals to meet the needs of regions do not include policies or strategies for minority groups, such as indigenous New Zealanders, or specifically for women, then the 'funding bump from south to north' will indeed be 'like a thin snake swallowing an egg'¹—an egg of inequity.

'The system may be rational on its own terms while perpetuating social inequalities'

... And The External Pressures?

The Minister assumes that health care is a professional service that is provided only as needed. He makes no mention of the power of the medical profession or of the various pressures to increase high-tech medical interventions. Over-servicing may occur for a number of reasons—patient demand, fee-for-service payments, promotion of medical technology by its manufacturers, 'defensive medicine' to decrease risks of legal action—none of which can be addressed by Mr East's framework of rational

allocation, since the framework does not provide for the scrutiny of decisions by the professional providers. It is merely assumed that clinicians will (somehow) ensure the 'most effective use of resources' by deciding 'ethically', as if there is only ever one *ethical* decision that clinicians can make.

... And Alternative Strategies?

There is no mention of alternative strategies for health improvement either. These might include:

- the provision of greater economic security for the populace, which is associated with improved health
- promotion of better diet and exercise, not just through appeals to individuals but also by subsidies for, or taxes on, relevant foods
- more vigorous efforts against smoking
- efforts to reduce industrial accidents and hazards
- the promotion of alternatives to the car, itself one of the major technological hazards of our time.

Needless to say, many of these measures are highly controversial since they challenge 'business as usual' in various ways. But whatever the pluses and minuses of these alternatives, the point is that most of them are rarely even considered as part of health policy—this is usually restricted, as in the Minister's speech, to the provision of (medical) health services.

Almost without exception today's politicians seem to want to argue at the most superficial level they possibly can. But even this cannot hide contradiction, and Mr East's speech is no exception. For instance, in **myth nine**, he addresses the issue of money, and says that this is not the appropriate benchmark by which to judge the public health system. Yet in **myth three**, the Minister welcomes the financial contracts his government has insisted that RHAs and public hospitals enter into, and which limit the number of operations which can be performed at any one time by the amount of money contained in the relevant contract.

'Almost without exception today's politicians seem to want to argue at the most superficial level they possibly can'

Furthermore, while the Minister calls for a vigorous debate, he directs the reader to take away certain 'facts' which he claims to be inviolable—hardly the basis for an effective debate. In short, the Minister's speech reflects a standard professional-bureaucratic model of health care. It is an immense challenge to move out of this framework, which has an enormous institutional momentum as well as a hold on many people's thinking. It is especially difficult for a politician to open the door for any consideration of fundamental alternatives in health, since this means both challenging vested medical interests and stepping on toes in other ministries, as well as coming under attack by political opponents.

There is much of the popular television series *Yes Minister* in this document. It has the appearance of laying self-constructed myths to rest and defending changes to the New Zealand health system. But that is only the image. The real purpose of the speech is to defend present arrangements, and in doing so the Minister has denied the system and its principal players the opportunity to go beyond the present to develop new approaches and new ways of maintaining good health, and addressing ill health.

'The real purpose of the speech is to defend present arrangements'

Finally, in his quest for a vigorous debate the Minister has overlooked his strongest constituency—doctors and nurses and policy-makers—who may be witness to bad practices and who have many ideas on how to improve the health system. There is no reference in the Minister's speech to the contribution these players could make. If there were no restrictions on doctors, nurses and policy-makers in the public health system to engage in public commentaries, both the debate and the health services would be significantly advantaged.

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Reference

1. Some of the quotations used in this paper are taken from the complete version of Mr East's speech, copies of which are available from the editorial office.

Who is Doing the Myth-Making?

Andrea Steiner

Like their predecessors, modern societies rely to a great extent on idealisation to affirm national identities and develop support for public policies. Social myths may have only tenuous connections to the truth at times, but are no less valuable for that. They create impressions in the public mind which in turn form the basis of social behaviour and public pride.

In his rebuttal, New Zealand Crown Health Enterprises Minister Paul East reveals his awareness of the importance of social myth-making. He follows the rhetorical device of setting up and debunking 'myths' about the health care system. In the process of 'replacing the myths with facts' (as he describes it) Mr East manages to promote some myths of his own, the most important of which is that community-based primary care is the next panacea. This new myth is being promulgated around the world, so bears some scrutiny.

My comments will follow two paths. First, I have some specific thoughts regarding the particular myths. Second, I have some more general ideas about the underlying agenda of the Minister's speech. On the whole, I found the speech pleasing in that Mr East spoke forcefully and positively to reassure New Zealanders that access and quality would be protected while at the same time he boldly confronted the difficult issues of systematic restructuring and resource allocation ('priority setting or, more emotively, rationing,' as Rudolf Klein has written).¹ However, although I admire Mr East's directness, I am not so sure about his new myths.

The Minister's Myths

The Minister begins by denying emphatically that his government is cutting back on health care funding and activity in public hospitals. In

fact, he says, funding has increased some 18% over the last 2 years (my math has it at 20.7%) and the volume of hospital-based services has increased a modest but definite 4% annually over the same period. But are these figures stated in real or nominal terms? Probably they are nominal. Has demand changed over the same time period due, for example, to population ageing or improvements in access? Relative to actual need, then, has there been a net loss or a net gain in the amount of care funded and provided? This is what the public would really like to know. Malcolm and Barnett reported that from 1983–1992 there was virtually no real increase in expenditure or service use.² Does this suggest a level of under-care which needs to be brought up to standard—if so, are the current increases sufficient—or has the system found a workable maintenance level for providing care?

We cannot tell from the speech, but Mr East's **myths three, four, and five** suggest a public perception that current levels of care are not adequate. They reflect fears that budgetary concerns dominate medical decision-making, with the result that hospitals can delay surgery, expand waiting lists or withhold care from older people. Of course, it must be assumed that the Minister made a deliberate choice to confront these issues so plainly. It is his speech, and his straw men to knock down. Presumably, he wanted the opportunity to restructure New Zealanders' thinking. Mr East emphasises that it is only elective surgery that is delayed or withheld, that waiting lists are a poor measure of system effectiveness, and he acknowledges (eventually) that, yes, older people probably are going to receive less care.

'Evidence is accumulating that certain population subgroups are more likely than others to have their care termed non-urgent'

It is reassuring that there are no specific constraints on provision of urgent medical care. But what about the non-urgent cases? Although the Minister asserts that medical professionals (not managers) decide which cases are appropriately termed non-urgent, evidence is accumulating that suggests certain population

subgroups are more likely than others to have their care termed non-urgent. Women's cardiac care is one case in point;³ in the United States, black men's renal care is another.⁴ Procedures for older patients are virtually a stereotypical example and will be dealt with below. Thus, health authorities do well to guarantee that patients' acute care needs will be met, but they must scrutinise their definitions to guard against inequities. Mr East pays a great deal of attention to the issue of queuing for health care, reflecting the political freight that the waiting list marker carries in voters' minds. He makes five separate points about them, as well as four specific objections to using waiting lists as a measure of effectiveness. Unfortunately, these objections are garbled.

Garbled Objections

First, the Minister prefers a criterion of waiting *times* to simply counting how many people are ahead of you. Fair enough, but then he tells us nothing about his government's performance according to that preferred standard. Instead he touts a booking system which informs patients of their expected waiting time. Booked admissions may reduce patients' uncertainty, and so avoid some stress-related discomfort, but it reminds me of the New York City approach to 2-foot-deep and 3-foot-wide potholes on major 'arterial' roads: a sign is posted which says 'Pothole'. This may reduce the worst accidents but does nothing to repair the road. Second, who could be reassured by the fact that the length of waiting lists may be overstated because people have opted out (choosing private insurance instead), moved away, or decided against the treatment (or died)? Deleting those who have dropped out of the system may shorten the list but does not reflect efficient care.

'His assertions that increased age is associated with worse prognosis and less time to enjoy the benefits of treatment do not inspire confidence'

Third, the trouble with defining the waiting list problem as one of people waiting for inappropriate

treatment is that the list of treatments whose appropriateness has been established conclusively is, to date, rather short. Presumably people are placed on waiting lists by their physicians, who are acting with the best knowledge available to them. Finally, Mr East's point that, in the specialists' minds, privately-funded patients retain priority over publicly-funded patients is well taken but does nothing for individuals in the public system. It is a systemic flaw in need of resolution.

To his credit, Mr East concludes his comments about waiting lists by acknowledging that not only survival but also quality of life must come into play when physicians decide about surgery and waiting lists. Of course it is better to defer treatment for something non-life-threatening than life-threatening, but threats to function or quality of life are significant too. They may become mortally risky problems at any time. These are some of the problems with using age as a basis for rationing care.

Although the Minister claims that age 'in itself' is immaterial, his assertions that increased age is, after all, associated with worse prognosis and less time to enjoy the benefits of treatment anyway, do not inspire confidence. In fact, age probably is too convenient a marker to be ignored by medical decision-makers. In this pragmatic light, it may be that what is called for in the short term is to shift the unspoken cutoff point upward (say, to 80, 85 or 90 years) to reflect people's increasing life expectancy and to ensure that public health care services do not curtail individuals' natural potential because of cost constraints. At a certain point, withholding care is reasonable, even humane; however, few health care settings honestly reach that 'certain point' (when all that can be tried has been tried). Until then, better to focus on what can be improved about the care than on who can be bypassed in the drive to free up physicians' time or hospital bed space.

Myths six to eight enabled the Minister to introduce some financial thinking into the speech and to defend the professional labour pool. He is cagey on the subject of hospitals' fiscal performance, suggesting that there are a number of 'options' including 'helping' them to 'manage their resources better' and promising not to physically close them down. A small point about

the numbers: again, the math doesn't add up. At the beginning of his speech, Mr East refers to the 500 000 people who are admitted to hospital each year. Later, he says 2100 people are admitted daily. That's 766 500 admissions per year. Can it be true that, on average, more than half of all New Zealanders to be hospitalised each year will experience a readmission?

'More than half of all New Zealanders hospitalised each year will experience a readmission'

In **myth nine**, Mr East objects to the charges that '(T)he public health system is only about money.' Surely he is well justified in his objection. New Zealand is one of the few nations to take a centralised approach to health service planning.^{1,2} Only one of its four guiding criteria—value for money—is about economics. The other three—medical effectiveness, fairness, and consistency with community values—are not. But this is not to say that money matters not at all. This speech plants many seeds to do with fiscal responsibility. Twice Mr East asserts that there will 'never' be enough health care to go around. Remarkably, he says that clinicians have 'an ethical obligation' to make medical decisions based in part on economic concerns. This is a new myth, utterly different from the prior medical model which identified physicians as above financial concerns and as 'ethically obliged' not to think of money when making decisions on their patients' behalf.

The Agenda Beneath

Financial interests notwithstanding, something else lies at the centre of this address. The last debunked **myth** ('the public health sector is all about public hospitals') is, of course, the crux of the speech. Indeed, Mr East summarises his first nine points before turning to the tenth, rhetorically closing that portion of his talk. In the final section, the Minister speaks movingly about hospitals' growing obsolescence despite a continuing psychic presence in their communities.

The government's intention is to devolve care away from the high-cost inpatient environment into lower-cost, lower-technology, community settings. In so doing, it hopes to promote improvements in preventive care, a 'return' to a more holistic model of health services delivery, use of locally determined priorities, and greater responsiveness to residents' actual needs. Primary care is far less expensive, per unit, than secondary care; hence, there is an assumption that if more services can be provided at the primary care level, considerable savings can be realised. This is a potentially momentous change in health policy.

In the United States, it is only recently that health care providers have adopted an explicitly population-based 'health of the nation' orientation, through health maintenance organizations and other managed care enrolment plans. In other developed nations, public health insurance has been associated for decades with geographically determined patient populations. In both cases and around the world, we are witnessing a paradigm shift away from the heroic model of medical care, which emphasises sophisticated technology and survival at any price, to a more humanistic model which, in principle, values quality of life rather than heartbeats and according to which patients and their families work collaboratively with physicians to determine the medical choices that affect them.⁵

I refer to the humanistic model 'in principle' because a more cynical view of this new emphasis would call the humanistic model a myth, and claim that the new health policy, in reality, is simply a set of actions designed to cut costs. This new care places increased burdens on primary care providers, asking them to do some of what specialists used to do but paying them less than specialists would earn. Although it is likely that nurses can do some of what GPs have done traditionally, and that GPs can do some of what specialists have done traditionally, it is also possible that quality will suffer because of discrepancies in training. Moreover, the opportunity costs of primary care providers' taking on

'Around the world we are witnessing a shift away from the heroic model of medical care'

new responsibilities need to be identified, so that the purchasers and users of care can decide whether the shifts are suitable.

It must be asked as well what, exactly, is shifting? Are the purchasers of care actually moving resources from one sector to another, are they shifting professional control of the care, or are they increasing communication between primary and secondary care providers? These will have different implications in terms of their acceptability to practitioners and probability of success.⁶ In the United Kingdom thus far there is much more talk of shift than actual action, and many more 'shared care' interventions than actual transfers of control. This seems natural, but the fiscal effects may be less profound than originally intended. In the United States, managed care models emphasising primary care for health promotion, preventive care and gatekeeping purposes are replacing traditional fee-for-service care, but the evidence regarding their effectiveness is not yet in.

Moving care out of the hospital is a risk. The gamble is that, by treating more of the people (virtually all of the people) for most of what they need (namely, primary care services and simple procedures of a more serious nature) as well as treating some of the minority who need highly specialised care at regional centres, the overall health of the nation will be better than if more people used specialist care but fewer received primary services. At a minimum, the plan assumes that if health outcomes remain constant, health expenditures will be reduced. Under no circumstances, the gamble goes, will health outcomes be worse. This simply is not known. It is true that some of the greatest advances in life expectancy have come not from medical care *per se* but from public health measures such as improved sanitation. Public health interventions may indeed prove more profound in the aggregate than medical miracles.

'Patients who fall into high-risk categories will do well to get themselves out of those categories wherever possible'

A likely consequence of shifting the public health service out of the hospital is that societies will have the opportunity to discover the limits of health promotion. With a health care model that emphasises self-care and primary prevention, patients will find that they are responsible for their own good health—for quitting smoking, managing diet and drink, increasing exercise,

and coping with stress. In societies that are increasingly explicit about rationing care, patients who fall into high-risk categories will do well to get themselves out of those categories wherever possible or to compensate with high health performance in other areas (otherwise they face rejection as unsuitable candidates for life-saving procedures). Some real good may be associated with government's forcing patients to take care of themselves. Still, not all risk categories can be managed by will power. We must ask whether we want a society that neglects or rejects the imperfect as 'poor risks.'

Another possibility which must be acknowledged is that those who can afford to leave the public programme will do so, thus creating (finalising?) a two-tiered system. This should be worrying to any government because providers who operate with dual incentives—personal profit and an enhanced work environment on the one hand, civic duty on the other—will have to make trade-offs. It is more than possible that the lower tier will suffer. Ironically, by encouraging a stronger market orientation in the health service, the government may teach patients (consumers) to vote with their pocketbooks and desert a system plagued by waiting lists and rationing protocols.

The truth is that most people want the best of everything: holistic care following a humanistic model for most of our health care needs, but sophisticated technology following a heroic model in emergencies. We want support in improving our lifestyles preventively and in recovering from acute bouts of illness or injury. We are willing to pay, but not too much, and we want this care for everybody, but especially for ourselves and our loved ones.

Public health planners haven't the luxury of providing it all; they haven't the capacity to do it accurately for all members of a diverse society anyway. Despite these limitations, public officials do play an important role in shaping citizens' thoughts. The most important myth of any public health service must be that 'this government cares about the health of its people.' This is the myth that should inspire policy development and against which health policies should be measured.

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East: A Compass Correction

Edward Harris

A close observer of the last decade of upheaval in New Zealand's medical system may be thought insufficiently impartial to offer useful criticism of Mr East's speech. On the other hand, readers elsewhere will probably be unaware of local circumstances which bear importantly on its content. It seems worth trying to fill this possible gap.

This speech was made to a provincial Division of Mr East's National Party which, like the Labour Party which preceded it in office between 1984 and 1990, is inspired by the doctrines of the New Right. Party speeches commonly generate a mixture of good sense, special pleading from selected evidence, innuendo, political knockabout and outright sophistry. This one is fairly standard.

The Minister opens by quoting a newspaper's 'story' of a survey for 1994 made by *Consumer* magazine¹ among 12,000 of its 'non-business' subscribers. The survey's questions (answered by 9,356 respondents) were not about what Mr East calls 'public health' but about hospital and specialist care. They excluded maternity and antenatal care, emergency treatment and geriatric

care. They explicitly 'did not look at the quality of medical treatment, as this cannot usually be judged by patients'.¹ In *Consumer's* report, 'most people' means anything more than half the respondents to any question. And the magazine reports a small but significant decline in respondents' approval since an identical study for 1992 and 1993.

To buttress this distinctly shaky evidence that 'most people are happy with their experience of public health', Mr East then cites 'customer satisfaction surveys carried out by each of our 23 Crown Health Enterprises'. These surveys were prescribed in detail by the Prime Minister and Cabinet in 1993, in a 40-page document called 'Crown Health Enterprise Performance Reporting Measures'. The opinions of 200 ex-patients of each CHE (a hospital or a hospital group) were to be sought each month on such marks of hospital performance as decor, direction signs, cleanliness, cultural sensitivity and car-parking capacity. The exact wording of the 25 questions was specified. Remarkably not a single question was about the clinical care provided or the 'customer's' satisfaction with that, and the questionnaire ends by asking 'Would you recommend our hospital to your friends?' The rest of the 'Performance Reporting' document is replete with logical, statistical and even grammatical errors, but its endorsement before publication by two unidentified international firms of consulting accountants evidently carried the day.

'Remarkably not a single question in the survey was about the clinical care provided'

This, then, for a start, is the sort of material from which Mr East (a lawyer) selects what he uses as evidence in this speech. Next, dissenting views are firmly labelled 'mythology . . . created by those with particular agendas'. Mr East even hints that the public system is, according to his view of 'reality' and contrary to the myths, so satisfactory that private medical insurance is unnecessary. Could it be that hard-headed insurance companies, which have precisely those 'particular agendas' that right-wing governments so admire, are among the myth-creators?

Mr East demolishes his first **myth** by asserting 'an increase of around 18%' in government

funding, and **myth two** by reporting a corresponding increase of 'around four per cent' (8% over two years) in 'total services provided'. On the numbers given, funding actually increased by 20.7%. 'Efficiency', judged by output for money, thus seems to have *decreased* by at least 10% (1 minus 108/120). And this, moreover, occurred at a time when, according to many observant myth-creators, the managerial component of 'total services' had risen conspicuously. A time, too (like all other times) when the government's 'health reforms' were supposedly generating 'more health for every tax dollar'.

Public complaints about waiting lists are, in New Zealand as everywhere, widespread. They will doubtless be deflected for the moment by the standard emphasis on waiting *time* as the real concern, and Mr East follows this line under **myth four**, namely that 'waiting lists ... is (sic) growing longer every day ...'. He points out, correctly in one sense, that 'medical advances ... often increases (sic) them.' The inherent link between 'list' and 'time' seems likely gradually to erode the suggested distinction. One may overlook the Minister's slip (or was it a slip?) in thrice suggesting that anybody might *want* a gall-bladder or heart operation, however much (s)he might need one. Far the most 'wants' in surgery arise out of pressing *need*. Mr East would certainly need, and thus 'want', a cataract operation if he couldn't see the newspaper stories he talks about. But his choice of this example badly damages his case as a champion of the public system. Cataract operations are a rich seam in the private gold-mine here, and public waiting lists/times are especially long for them.

'It is unfair to criticise specialists for doing what his policies strongly encourage'

Mr East apparently recognises what many myth-creators see as one of the glaring contradictions in a mixed public/private medical system, namely the conflict of interest which besets specialists who have both public and private commitments. He should, perhaps, think about this revelation very carefully, for it goes to the heart of his faith in the superiority of commercial incentives in providing medical care. He is saying that senior specialists can be—indeed are—influenced in the discharge

of their clinical duty by the promise of money. The thought seems to trouble him. (It is hard to see why. Is not self-interest the mainspring of his idea of the good society?) It evidently does not trouble him very much, because if it did he would surely remedy it at once by requiring specialists to choose between public and private practice. Doctor-bashing is always good for applause, but it is unfair of him to criticise the specialists for doing what his policies strongly encourage.

In rebutting **myth six** Mr East was understandably restricted by having to observe the rules of commercial privacy. Managers of CHEs, he suggests, are not overpaid. That may very well be true, but to demonstrate it he would need to reveal what they *are* paid. That cannot be done, since CHEs are supposed to compete with each other. So he just says that 'salaries reflect the size of the institution' and 'generally, these salaries are lower than ... in the private sector'. But public suspicion is surely not all that surprising. Mr East may remember the old days of public service, when the salaries of managers were a matter of public record. Not being elaborately concealed, they were seldom questioned.

Under **myth seven** we learn that '(A) loss occurs when it costs more than it should to efficiently provide ... services, or the hospital provides more services than it is contracted for'. This raises important questions about the reality that Mr East believes he is restoring. What precisely, in this particular context, is 'efficiency'? How much *should* the services cost? How is that figure arrived at? Who decides? Cannot the government, by withholding funds, make a hospital insolvent whatever it does? How is a hospital supposed to judge which clinical needs to ignore in deciding what services to provide? What ethical implications are involved in that? What, in 'reality', is a hospital's *purpose*? These are the kinds of question, perhaps, which Mr East chooses to ascribe to 'particular agendas', and thus leave himself free to deem irrelevant. Certainly they are not questions that would cause much difficulty for those who sell second-hand motor cars. What is difficult to understand is Mr East's puzzlement (**myth nine**) at any suggestion that the 'public health system is only about money'. This speech seems admirably crafted to reinforce that view.

The Minister's best opportunity to say something sensible started with his demolition of **myth**

ten. New Zealand's population is about 3.5 million, in an area one-sixth bigger than that of Great Britain. It is not remotely practical to have a full range of medical services on everybody's doorstep. Carefully planned centralisation of hospitals is thus essential to make the best use of what is available. Some small, clinically beleaguered hospitals must go in the process. Their patients must be guaranteed prompt transport to base hospitals when they need them. A few carefully-placed base hospitals may have to be built. Treatment of complicated illness is sensibly provided only in four or five major centres, again with planned and guaranteed transport.

I imagine that few informed critics would seriously disagree with the foregoing outline. It, or something like it, is *clinically* necessary. Yet there has been widespread protest in the smaller towns, and in rural areas, over repeated moves towards closure of small hospitals.

Why? Partly, of course, because of anxiety about losing local hospitals that have earned the reliance, loyalty and pride of their public over many years. But surely, too, because the government, like the business people they appoint to manage the system, constantly present the problem as a commercial one. A hospital is going into debt. No business could carry on like this, they say. It would be liquidated, and so must the hospital. That is precisely what a senior architect of the present policies (a businessman, naturally) said publicly three or four years ago. Under **myth seven** Mr East seeks to blur this view, while not actually denying it: 'The government is not about to physically shut down Crown Health Enterprises because they are not financially viable'. *About to?* (Elsewhere he says that his government is not *about to* privatise the medical system. Alarm bells ring!)

'He invites us to believe that our mental hospitals spontaneously disgorged their patients into the street, altogether unprompted by the government'

But of course Mr East knows that hospitals are closing anyway. He asks: 'Should we ignore the movement from hospital to community ... depriving the system of the funding flexibility needed to make the change?' He invites us to believe that our mental hospitals, for example, spontaneously disgorged their patients into the

street, altogether unprompted by the government. (It certainly did not happen because the public wanted it, though Mr East does not mention this.) The 'movement' is (like 'business confidence', or stock-market booms and slumps) a mysterious and irresistible tide in our affairs, to be met reactively by 'funding flexibility', whatever that is. The idea that it might cry out for responsible planning would occur, presumably, only to people with 'particular agendas'.

That the Party faithful should accept this sort of thing as serious argument is not surprising. Why the general public seem so ready to do so is more puzzling. The key, I think, must lie in the steady presentation, by ministers, managers, advertisers and journalists, of medical care as an ordinary commodity, to be traded like cosmetics. If that be accepted, then to argue against commercial medicine is to argue, by extension, against commerce in any form. Moreover the New Zealand public have never enjoyed free visits to the doctor, any more than free plumbing services. In turn, New Zealand doctors seem widely content to be regarded as business people. To this extent, medical care is already accepted here as an ordinary commodity. To question an established system takes a degree of philosophical independence that is rather scarce, and that Mr East and his colleagues are naturally at pains to discourage.

It is difficult to regard the Minister's speech as a serious contribution to an improved medical service for our people. It is equally difficult to imagine that he meant it to be.

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Cultural Diversity, and Some Advice for the Minister

William H. Oman

In his address the Hon Paul East makes the point that modern medicine has no national borders.

Island countries such as Japan and New Zealand, he says, are able to construct medical systems which are flexible and responsive. The comparison is interesting. Japan has perhaps the most efficient and most effective health care system in the world. Mr East suggests that the health care expectations of all countries are fusing into a range of similar expectations, even in a country as culturally diverse as New Zealand. Mr East does acknowledge that the level of health care should be determined in part by its value relative to other cultural values. He is diverted from further cultural considerations by the pressure to respond to critics who question the viability of the public health system on economic grounds. Thus, he does not address how health care in New Zealand will actually be limited by 'other values'. I think it is a critical omission, if not from this speech, at least from the overall debate about what constitutes 'adequate' health care for some segments of a diverse population. Mr East turns instead to an attempt to find a culturally neutral 'objective' limitation on health care which all countries must submit to: the scarcity of medical resources, which defines limits to their macro-allocation at the global level, as well as within individual countries.

'Mr East suggests that the health care expectations of all countries are fusing into a range of similar expectations, even in a country as culturally diverse as New Zealand'

Mr East speaks primarily about the political challenge of distributing a range of needed human services which are in chronically short supply in a fair and just manner. Looking at health care as a basic human need (and, though from the most worthy motives, thereby homogenising the health expectations of diverse cultural sub-groups) the most equitable arrangement was assumed to be to create a system which anyone could access, a public system of health care, akin to a public system of education.

In the United States, public education has fallen under fire for some of the same kinds of reasons. Public education has also had the effect of homogenising diverse cultures. While there has been a movement afoot for some time to

reintroduce diversity into the curriculum, it has taken a back seat to the more intense pressures from economically-motivated critics. The same kind of pressure seems to be on the public health system in New Zealand, with the result that cultural diversity is not part of the equation at the moment. There is too much of a job just defending the idea of a public system at all.

Today special interest groups are pressuring New Zealand's and other governments not to be so equitable. The special interests do not want to say 'me first' in so many words, so they mount an attack based on 'efficiency' and 'waste of public money' or 'inferiority of public vs private services'. Mr East tries to meet the critics on their own ground. For this reason, he tries to talk about public health care as if it were a commodity on the same order as electric power.

'Mr East tries to talk about public health care as if it were a commodity of the same order as electric power'

An Effective Speech

Having joined the battle on his opponents' preferred playing field, Mr East's response is subject to the limitations of treating health care only as one more service for pay. Within that limitation, however, he does a credible job of meeting their criticisms. First, citing a consumer survey, he defends the efficiency of the public system. Second, he gives information to counter the assumption that the system is not planning or is wasting its money solely on hospitals when at least half the health care money is for non-hospital related care. Third, he argues that productivity has increased, i.e. that the health care system is treating more people more effectively. Finally, he pooh-poohs the rumours of failure within public health care as the manufactured opinions of special interests who have everything to gain by its demise.

Mr East is clearly offended by self-serving attempts to stampede the public with misinformation, including the ease with which the press allows itself to be duped into broadcasting

hasty generalisations from half-baked statistics. Mr East seems especially effective in showing the manner in which information about one commonly heard complaint, lengthening lines for elective procedures, has been manipulated.

The number of people in line for a procedure, he notes, means virtually nothing. Patients who used to spend six months in recovery, may spend more time waiting for a procedure, but only a few days in recovery. Such technological advances make procedures more practical and less expensive and hence attract more people who want them. In this way lines 'lengthen' for all the right reasons. Although Mr East is too polite to put it this way, his critics are like someone who complains that the reason we should not inoculate the population against infectious diseases is that there would be long lines waiting for the shots. The special interests act as if waiting in line is worse than typhoid.

The flip side of unfair criticism of the public health system is to manufacture the unrealistic expectation that private health services would eliminate lines (for those who had the money to pay for them—although they do not spend much time hawking this information). The way the lines will be cut down is not through increased medical efficiency, but simply because it would be futile for those without money to stand in line. If reducing the line for elective procedures becomes a one-shot litmus test for the status of health care, then charging everyone more money for health care reduces the lines, i.e. it improves health care.

Mr East makes a forthright attempt to show how arguments complaining of lack of efficiency and effectiveness are skewed. He clearly understands the mischief that has been done by allowing the moneyed interests to define the debate in terms which lead to their own private gain. Among those who succumb to the argument, however, are too many health care professionals. If Mr East writes a second speech, I would hope it would return the discussion of health care to the problem of helping others, which he seems concerned about, rather than have it continually defined as a way in which individuals are led to see only their own gains—to the exclusion of their obligations to put up with inconveniences so that others less fortunate can also benefit. The notion that one would scrap

a health care system because it made one wait in line cries out for Ionesco, not for economics.

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Response from The Minister of Crown Health Enterprises to The Commentaries

It is difficult to reply to all the points raised in the commentaries on my speech in both the short time frame given and the word limit imposed.

It is important to remember the context in which the speech was delivered. It was a political speech given to everyday people putting another side to what is a highly charged political debate in New Zealand.

General

Most of the commentaries throw further light on the debate about how to match the provision of health care with people's needs, wants and a nation's ability to provide that care.

Interestingly, some of the commentaries themselves expose the level of conflict which exists amongst the different views. For instance, one piece advocates a greater emphasis on preventative measures while another says we should put more emphasis on hi-tech hospitals.

Each person, academic or otherwise, will believe in the need for different priorities. These conflicts are unavoidable as we all have different viewpoints, positions and interests.

It is these conflicts which the government must resolve. This is what politicians are elected to do and decisions must be made in order to keep funds flowing to government provided services.

This process, which is political, means not only resolving conflicting priorities within one area such as health, but also between other areas such as education, welfare support and providing a sound economy. In addition to the resource allocation problems there are also matters of balancing the rights of individuals and the common good.

Many academics find this process unpalatable, because it can appear chaotic and illogical. In many cases, it is illogical. How else do you reconcile the irreconcilable and measure the mutually incomparable while reflecting public opinion and all the time following the political credo you were elected to represent?

Commentaries in Turn

Martin and Mitchell raise some valid points, but they fail to recognise that the speech in the main was addressing the public hospital problems. They would be interested to know that the majority of the preventative measures they discuss are being actively pursued in New Zealand.

I also accept their points that inequities other than historical population funding patterns do exist. In New Zealand we have a definite problem in differing health status between ethnic and geographical groups. These are also being addressed, but will not be solved as easily as a formula on paper.

Steiner asks numerous questions which I will attempt to answer. There has been a recent net gain in health expenditure by the government, the pattern has generally followed New Zealand's economic path over the last decade with occasional bursts prior to elections in the 1980s!

Whether the overall amount of government spending on health is adequate will always be a matter of debate. The factor which has driven me in the past few years has been the need to place the hospital sector on a sustainable financial footing, for it was clear that prior to the health reforms in this country, the public hospital infrastructure was being run down. For instance, there was no accounting for depreciation of equipment. I am sure that putting in place proper accounting and management principles will mean our hospital sector will be able to face the next century on a sound footing.

The replacement of waiting lists with waiting times and booking systems is in its early stages but I am confident that it is a far better measure of need and supply.

I do not accept Steiner's contention that all people on waiting lists are in equal need and that all doctors treat patients and waiting lists in the same way.

Harris tries to cast doubt on the improving performance of New Zealand's hospitals by

attempting a false comparison between two sets of data, i.e. increase in health spending against increasing hospital outputs. He is incorrect—not all health spending increases have gone to the hospital sector and health costs have not remained static either in the hospital sector or the primary sector.

His attack on my advocacy for efficiency in hospital care, i.e. best value for money, is revealing. Harris seems to be saying that every hospital provides identical services and identical quality for identical cost. This is not true, as any examination of benchmarking anywhere in the world would show him.

Foreign readers might be bemused by Harris' reading of secret messages in my speech (I wonder what I would be saying if he played it backwards) for the benefit of a foreign audience. The government has long been accused of having a secret agenda of selling off ownership of the public hospital system. It is a tired old argument and I reject it by pointing out that the Crown's ownership is enshrined in law and I do not foresee any parliament in my lifetime changing that law.

Harris is out of line when he suggests that this government's policies are forcing health professionals into both the private and public health camps. This situation has long existed in New Zealand and many people have speculated on the perverse incentives. There are a number of solutions, but I am not willing to restrict health professionals' right to work as they wish.

Finally, Oman is correct in pointing out that there are other values outside those covered in my speech.

My speech did concentrate on macro-allocation and I should add that there is a great deal being done to recognise that different groups have differing needs which need to be addressed in different ways, both culturally and geographically.

He is perceptive in recognising that different interest groups do tend to use attack as the best means of defence in preserving those interests.

I too hope that one day debate about health care, health funding and health care organisation is considered on wider grounds instead of argument based on self-interest and refusal to accept that there could be other priorities besides one's own.

Paul East

Former Minister for Crown Health Enterprises,
New Zealand