

The New Zealand Health Reforms - Ethical or Unethical ?

Dr Anna Holmes, Professor Laurence Malcolm, Hon. Simon Upton

Dr Anna Holmes
General Practitioner

The Cartwright enquiry focused the attention of New Zealand on ethical issues in research. Research which fails to obtain informed consent is unethical. I submit that the current health reform is unethical economic research for which informed consent has not been obtained and for which there is no scientific validity.

The proposals in "Providing Better Health for New Zealanders"¹ are designed to test the theory that market forces and competition in health care will make better use of the health dollar. Such radical restructuring of a health service has not been attempted elsewhere and no evidence of its effectiveness is produced.

Health reform proposals signal a philosophical shift from community responsibility to individual responsibility for health. This is a form of social Darwinism or survival of the fittest and ignores the dynamic relationship between the personal and community aspects of health. It suggests everyone starts with the same resources, "a level playing field", even though health status measures show clear differences due to income and education. It is best illustrated by two ministerial quotes. Michael Savage, introducing the Social Security Act in 1938, said "What is there more valuable than to be our brother's keeper". Simon Upton, in 1991, said "I cannot control peoples' lives, I cannot make people live healthy lives, therefore I cannot be held accountable for their health status. However what I do control, on behalf of the Government, is Government expenditure on health services."²

Health researchers must submit research proposals to ethical scrutiny. Principles of ethical research include beneficence, autonomy, professional integrity, justice and scientific validity. Do the reform proposals address these principles?

Beneficence means doing good and avoiding harm to subjects. It implies a profound respect for the uniqueness and individuality of each person.

Respect for the uniqueness of each individual is certainly not part of the reforms. Categorising people according to their socio-economic group interferes with their treatment as unique individuals. The reforms are reducing access to services with potential for harm to individuals and community.

Autonomy leads to free and appropriate choices about health care. It is safeguarded by access to health information.

Access to information about health has reduced. Reasons include the rate of change in management and structures of health and consequent loss of institutional memory; the language of health reform documents^{1,3,4,5}, making them inaccessible to readers of average ability; payment for information which used to be free and refusal to share potentially commercially sensitive information.

Poor people have limited choices in health care. In 1991-92 welfare benefits were reduced and state house rents raised reducing their disposable income. The cost of user part-charges, transport, prescription charges and loss of access to public hospital and support services selectively affect the poor.

Professional integrity identifies the impact of what is proposed on the practice and profession of medicine.

This will be seriously compromised by the health reforms. These ignore individual differences in patients and promote competition among health carers. Commercial sensitivity will reduce professional information sharing.

Public hospitals are to be set up as "for profit" Crown Health Enterprises in the reform. An American study shows doctors were discouraged from admitting "unprofitable" patients to "for profit" hospitals when there is increased competition⁶.

Justice recognises equal access to needed health care and community responsibility for caring.

Health reforms have focused on individual responsibility for health and sickness and absolved the community of caring for all its members.

Access to core services is the equity concern of the government. It intends to eliminate income as a rationing device within a narrow band of core services. The core will be the basis for public funding, but not defined until after the election^{5,7}. Potential Crown Health Enterprises will shed "not profitable" services for their economical survival in the interim reducing the available core.

Between 1980 and 1991, before user part-charges, the government contribution to health expenditure fell from 88% to 81.7%.⁸ In the year ended 31 March 1992 household expenditure on health rose 18% and on medical goods it rose 13%, while food spending reduced by 5%.⁹

"Many people thought the core of the Welfare State was a dignified life for all, regardless of circumstances. But now poverty is not a great political problem for the National Party."¹⁰

"There are now record numbers of social welfare beneficiaries ... and ... working poor who rely on the charity of voluntary agencies to avoid destitution."¹¹

Lower socio-economic groups do not obtain needed health care in a free market model of health care.¹² Others have difficulty with a monocultural health system.

Efficient business managers are expected to extract enough savings from the present health service to pay the costs of reforms and their considerable salaries.¹³ If the savings are not possible, money will be moved from treatment services to administration to balance the books.

Conclusion

A major study showed that government funding of health with comprehensive cover and no cost sharing by patients is most likely to achieve equitable access to health care.¹⁴ This was the system in New Zealand up to 1991.

No convincing evidence has emerged that current reforms in health will do anything other than reduce available services to the poorest people and increase administrative costs. In terms of beneficence, autonomy, justice and professional integrity the current health reforms are inadequate. Their scientific validity is questionable.

¹ *Providing better health for New Zealanders*. Report to the Government and the New Zealand Public of the National Interim Provider Board, Wellington, May, 1992.

² Hon Simon Upton, Minister of Health. Address to Health policy Seminar organised by the New Zealand Institute of Public Administration and the New Zealand Institute of Health Management. Wellington Hospital, Wednesday 20 February 1991.

³ *The Core Debate 1 - How do we Define the Core?* Department of Health, Wellington, 1991

⁴ *The Core Debate 2 - Review of Submissions*, Department of Health, Wellington, 1992

⁵ Numerous speeches by the Ministers of Health, Associate Ministers of Health and Finance widely distributed at press briefings and to area health boards.

⁶ Schlesinger, M. 1987. *Paying the Price: Medical Care, Minorities and the Newly Competitive Health Care System* *Millbank Quarterly* 65(Suppl. 2) : 270-96

⁷ Speech of the Chairman of the National Advisory Committee on Core Health Services, April 27, 1992.

⁸ *Health Expenditure Trends in New Zealand 1980-1991*. Department of Health, Wellington, 1991

⁹ *Statistics Hot Off the Press: Household Expenditure and Income Survey for the Year Ended 31 March, 1992*. Department of Statistics, Wellington.

¹⁰ *Poverty - Business' Emerging Dilemma*. *Management* 39 (8) : 36-44 (1992) Wellington

¹¹ *Poverty - Editor's Note* *Management* 39 (8) : 7 (1992), Wellington.

¹² Aday, L.A. (1976) *The Impact of Health Policy on Access to Medical Care* *Millbank Memorial Fund Quarterly/Health and Society* 54 (2) : 215-33

¹³ *Unshackling the Hospitals*. Report of Hospitals and Related Services Taskforce, Wellington, 1988.

¹⁴ Fein, R. (1972) "On achieving Access and Equity in health Care" *Millbank Memorial Fund Quarterly/Health and Society* 50 (4, pt.2) 150-90.

Laurence Malcolm
*Professor of Community Health,
Wellington School of Medicine*

There is continuing deep and widespread concern amongst both health professionals and the community about the health reforms. This is despite repeated assurances from the Minister that relatively little change will be noted in the way health services are provided in July 1993. Although there have been significant responses to public submissions and further rethinking regarding the organisation arrangements proposed in the *Green and White Paper*, there appears to be little public or professional support for the reforms.

Increasingly, questions are being asked about the ethics of this major social "experiment". It is claimed that the Government had neither ethical nor democratic approval for such a major reform process. This article examines some ethical aspects of the reform process under the headings of four of the basic principles of ethics:

- will they do good (beneficence)
- will they do no harm (non-maleficence)
- will they improve access and equity (justice)
- will they give providers, patients, consumers in the community a greater voice in the provision of health services (autonomy)?

Beneficence

The stated aims of the *Green and White Paper* were to improve access to health services at lower cost (to Government). Its most fundamental flaw was the lack of any vision for a healthier New Zealand. Despite the title there was no indication that better health was the desired outcome of the new system whether achieved by public or personal health services. Better access is only one factor in ensuring better health.

More recently however, the Minister appears to have come to the view that health status is important. In a recent address to the New Zealand College of Community Medicine he stated that the first goal of the reforms "is an improvement in the community's health status". The Public Health Commission will be given the responsibility for formulating and advising on national health goals and objectives to be achieved by both personal as well as public health services.

The greatest potential benefit from the reforms could be the bringing of the general practitioners and other primary care providers into an accountability relationship with RHAs and CHEs. It is surely unethical that over \$1 billion of Government expenditure, which until recently has grown at inflation adjusted rates of nearly 8% annually, should be unconstrained by any significant accountability mechanisms for outcomes, value for money, equity in geographical distribution or between various components such as the relative mix of benefits. Mechanisms to achieve accountability through GP contracting or even fundholding or a managed primary health care service offers considerable potential for both achieving better value for this expenditure as well as shifting the focus away from the present heavy emphasis on institutions and secondary care services.

Non-maleficence

There is still widespread concern that the reforms could seriously damage an already stressed health system. The greatest potential damage could occur from the Government's intention that CHEs should focus on financial rather than health outcomes, ie that they should do "well" rather than doing "good". This emphasis on the profit motive would be seriously discordant with the goals of health professionals working in CHEs and could lead to serious compromises with quality, to adversarial rather than collaborative relationships and the withholding of information thought to be commercially sensitive but which is necessary to patient care.

Other harmful outcomes which have already occurred have been the interim part-charging regime and its limitation on access of those in the lower income levels of Group-3 to GPs, prescribed drugs and area health board services.

Also potentially harmful could be even greater fragmentation than exists at the moment as a result of RHAs purchasing fragments of services rather than an integrated service system.

Justice

The Government argues that its reforms will be fairer in that they will ensure access to an agreed core of services on affordable terms and within a reasonable time. The interim part-charging regime was intended to ensure that those who could afford to pay (the slightly better off, Group-3) could assist in providing better access to those who

could not (Groups 1 and 2). However, the small amounts being received, and mainly from those at the lower income range of Group 3, raises questions about the practical value of this policy quite apart from the serious political fall out.

The integration of all funding, including for disability and ACC under RHAs, who will have an explicit responsibility for purchasing a balanced set of services, could do much to bring about a fairer distribution of resources between the various components of care than exists at present. There is much evidence that what is needed in the New Zealand health system is not more funding but:

- a shift from a still overbedded institutionalised system to community-based care
- a shift from secondary to primary care including community self-help
- a better balance between acute and long term care services
- a greater emphasis upon public health services which could be achieved through the Public Health Commission, but at the same time the need to integrate all health services both personal and public at the provider level.

But how effective will RHAs be as purchasers when they are new, relatively inexperienced bodies in contrast to well established providers?

Autonomy

The shift away from institutional to community care and from secondary to primary care, especially if local communities are involved in self-help activity and have a greater voice in their own primary health care services, should lead to an increase in autonomy. There could be particular advances in the autonomy of those needing long-term care through the development of a case manager approach through service management. However the integration of funding does not necessarily lead to the integration of provision. Moves towards consumer based funding, with those assessed as needing long-term care having a particular entitlement to purchase their own health services from a range of alternatives, could greatly increase the autonomy of those who now are being steered into an institutional bed by the incentives of the current fragmented funding systems.

The reforms appear to shift the focus of care towards greater individual autonomy and improving the ability of people to make better decisions about their own healthcare eg the management of their blood pressure,

diabetes, asthma and many other problems. It appears to signal a shift from the present provider dominated system to a more community focused one although there are legitimate fears that this is just cost shifting rather than a real increase in autonomy. There are also concerns about how well RHAs will be able to relate to local communities and their needs.

Conclusion

Are the health reforms ethical?

On balance it appears that there are significant potential benefits from the reforms particularly now that the Government appears to have moved towards a focus on health outcomes and improved health status for New Zealanders as its overall goal. Nevertheless, there are some serious risks particularly those associated with competition and the profit motive being imposed upon CHEs. The purchasing function, integrated through RHAs, could lead to a fairer, more balanced system, although integrated funding does not mean integrated provision. There appears to be an intention in the reforms to maximise autonomy with shifts into primary and community-based services although it is still far from clear as to how, except through local primary health care development, the community's voice will be heard at the RHA level.

There are some good features about the reforms but many questions remain. Despite their concerns health workers, dedicated to the care of both individuals and communities, will not let the new system fail despite being bemused, confused and often angry at the additional demands that yet another organisational change imposes on their increasing workloads. Quite simply the care of those for whom they are responsible is far too important for the changes not to succeed.

Hon. Simon Upton
Minister of Health

Your Editor has asked me to contribute to a forum on whether or not the health reforms can be described as an "unethical experiment". It was suggested that my contribution should be along the lines that the proposed health system will be "no more unethical" than the old one. That would be a strangely ambivalent reply to those who argue that the reforms are unethical. So let me take a more robust stand: the reforms will secure a more ethically defensible public health system.

First, let us be clear about what we mean by "ethical" in this context. To argue ethics in the context of public policy is to argue about how we ought to arrange our affairs. The yardsticks we will refer to will have something to say about the fairness or justice of those arrangements. We will want to ascertain the extent to which these arrangements are respectful of people - in other words, are individuals treated as precious in their own right rather than just a means to an end?

If we are to ask these questions of the present health system we face an immediate problem. Is it a system at all?

What underlying principle informs it? Take the question of access to health care. Largely, as a result of historical accident, the terms of access are highly variable. Many New Zealanders are entitled to benefit from the GMS if they visit a GP. The only trouble is, there may or may not be a GP close by. That is left to market forces - and remote provincial areas and some low income urban areas are not well provided. Alternatively, they may not be able to afford the extra fees charged by the GP - over and above the level of subsidy. Again, that has always been left to the market place.

On the other hand, access to hospital care remains free for half of New Zealanders (while the balance face very small charges compared with the cost of the treatment). But another barrier may raise its head. There may be access - but not when you need it. There may be a two year wait or longer for some elective surgery.

Or take the long term care of elderly citizens. If they are lucky enough to get into a public geriatric bed, it is free and there is no means test. If they occupy a

private geriatric bed (financed by public subsidy) there is an income test. If it is a rest home bed, there is an income and assets test. If they try to stay at home (as many would wish to do for as long as they can) there is very little assistance available.

In truth, the terms of access to differing services portray no discernible ethic. Maternity care is fully subsidised; dental care attracts virtually no subsidy. You may wait two years for an operation in one Area Health Board and six months in another. I would not say that is necessarily unethical, but to persist with such terms of access if a fairer system can be developed would be.

How about the vexed question of markets and medicine? Some critics of the reform insist that they herald a "free market" approach to health care in which profit comes before patient care. A reform that places 80% of all health expenditure in the hands of Crown purchasing agencies does not smack of a particularly "free" market to me. But again, reflect on present arrangements. GPs operate in a free market. They secure a considerable element of their income from fees levied on patients. So do many specialists. Some have a foot in both camps. They accept a part salary for their work in public hospitals and then take private fees for work done down the road in a private hospital. Does this make them more moral in one place of work than in another?

The focus for much critical comment has been the Government's decision to operate public hospitals as businesses that will be required to show a rate of return on the funds invested in them. This is, of course, no different from what a GP, a private geriatric hospital operator, or a private radiology clinic owner must secure. But it is a shock to many.

What is a rate of return? Very simply, it is a yardstick against which to measure the efficiency with which scarce capital resources are deployed. In the past we have had a system of giving health managers cash to spend on capital works. They have not had to face prevailing interest rates (although the Government has had to!) with the result that considerable sums have been wasted. We can all think of white elephants dotted around the healthscape in New Zealand.

I would simply ask what is ethical about having excess money tied up in bricks and mortar, or capital purchases, that is lost to services for people? Resources are scarce. Managers must be

accountable for their use. The real issue is not the rate of return. It is the motivation of the owner. Why does the Crown own hospitals? The answer is, of course, to see that people have assured access to some very costly facilities which also have important training and research functions. The Government does not own hospitals to make money. It owns them to provide a service. One way of guaranteeing the efficiency of that service delivery is to apply the discipline of a rate of return. The Government can then decide how much of that surplus it will return to the hospital (as a reward for good stewardship) and how much it may divert to higher priority health needs in other places.

It would help enormously if those who debate the reform of the health system were to focus on what the reform is about rather than some imagined agenda. It is, first and foremost, a reform of the way in which the Crown spends its four billion dollars on health care. The Crown used to focus on providers and how to subsidise them. In the reformed system it will start by asking the fundamental question - why do we spend this money at all? The answer is, of course, to secure health services for people. We start with the outcomes - better personal access to health care and better health status for the population - and only then work back to asking who may be best placed to provide those services. To my mind, it is an ethically superior model that makes the users of health services our primary preoccupation.

The reform secures the two principal objectives of any public health system: overcoming the inequality of resources that would secure much more unequal access in a private system and redressing the asymmetry of information that exists between patients and health professionals. By handing its resources to a purpose-built purchaser (the RHA), the Government is creating an agent whose task it is to stand on the side of the user of health services, and secure the best terms of access possible.

This new agent will be able to enhance, significantly, accountability within the public health system. For the first time the terms of access will be explicit. In New Zealand today, guaranteed quality standards are virtually non-existent. They will become, over time, essential terms of all contracts.

Secondly, our ability to monitor standards and provide users with access

to complaints and advocacy services will be improved. Thirdly, by being explicit about the cost of services, we will reduce waste. And, most importantly of all, the Government will front up on just what it is securing access to and what it is not.

For years, we have all pretended that the public health system gave us access to everything. It did not, of course, but we did not talk about that. You just confronted a waiting list or a bill and took it in your stride (or didn't). The Government is seeking to come out of the shadows on this issue and confront the fact that the public purse will only go so far (as it always has) and that we must, therefore, have some basis on which to set priorities.

It is the task of the Core Committee to advise us on this delicate issue. There are no answers. The Government is not seeking some highly explicit, priority-ranked list as has been attempted elsewhere. Such an approach is, to my mind, intuitively flawed in its moral vision. What we want, over time, is advice on the big broad priorities, the gaps we need to fill and the relative effectiveness of alternative options.

The fact that there are no answers is not a reason to avoid the questions. We know that any public health system will have to ration scarce resources. From an ethical point of view it is essential that governments front up to that truth and involve the public in the process by which we reach our conclusions. That is the Core Committee's mandate.

But we are also very much aware that governments cannot - and should not - enter the private ethical sphere that governs the doctor/patient relationship. There will always be clinical judgments that demand the exercise, not just of technical expertise, but wisdom and compassion.

These are the ethical responsibilities that health professionals have shouldered for centuries. Whilst it would be rash to deny that the rationing of resources in a world burgeoning with possible technologies and procedures does not impact on the physician, governments must always leave it to trained professionals to do what they think best with the available resources. Only in that way can we secure the needs of individual patients, each of whom is an end in herself, and for whom the whole public health edifice was constructed in the first place. ■