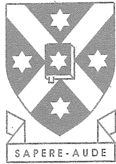

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Editorial

The American Dream

Professor Alastair V. Campbell

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Having spent the first six months of 1994 on sabbatical leave in Cleveland, Ohio, I find I have returned to New Zealand with a renewed sense of urgency about the dangers of our health system changes. I have many pleasant memories of what was for me and my family both a productive and a restorative time. But two powerful images remain as dominant memories: the first is of President Clinton's televised speech to Congress on the state of the nation. It was a powerful, carefully argued plea for adequate health care. At one dramatic moment he drew a pen from his inside pocket, declaring that unless a bill provided universal coverage for all Americans, it would never receive a signature from him! A second vivid memory is of a visit to the new University Hospital (not in fact owned by the university) next to the Case Western Reserve Medical School. Imagine the finest modern hotel you have ever stayed in and you will not begin to describe the grandeur of this place - marble floors in the elevators, acres of beautiful carpeting, and expensive tasteful furniture in totally equipped single rooms. The medical colleague showing me around wryly summed it up: "When patients feel well enough to notice how lovely this place is, it's time for discharge!"

This hospital was a powerful symbol of the commercial profitability of American medicine; the President's speech a Kennedy-like oratorical feat, symbolising youthful and caring leadership. Together they make up the American dream - one can be rich and successful, but also clear in one's conscience, because we all follow a national vision. The reality is far removed from the dream. Congress might cheer the President's moving address, but the next few months saw a remorseless whittling away of all the essential ingredients of his health care package. Powerful forces combined to make sure financial interests were not threatened. The American Medical Association committed a budget of $1.6 million to a print campaign warning the public that their advice was being ignored by government; the health insurers flooded the television channels with emotive advertisements predicting dire consequences from the changes. Meanwhile evidence of the current injustices kept appearing. In a country with hospitals (for the insured) resembling five star hotels fewer than half of all babies in major cities were fully vaccinated by age two (in Houston it was as low as 11%); public hospital emergency rooms were clogged with non-urgent cases (up to 55% of all attending) because of the lack of primary care for the poor; blacks on Medicare received less medical treatment than whites on Medicare suffering from the same condition; and evidence mounted that doctors who own expensive equipment (like MRI scanners) or who hold shares in medical laboratories order far more tests than those who have no financial interest of this kind. (I take these examples from a substantial file of press cuttings accumulated in the first half of 1994.)

So, when it comes to health care, more and more Americans (unless they have a financial stake in the status quo) are recognising that the dream is really a nightmare. The Clintons struck a chord when they pledged a reform of the health system, but the power to change things resides not in the White House, but in massive commercial forces which can easily mobilise opposition in Congress and can change the public's perception of the Clinton plan from one of hope for a better future to one of

distrust of the government and fear of change.

But what has all this to do with the changes to the NZ health system? In many conversations with American friends and in seminars with colleagues and students in various centres I encountered again and again sheer disbelief that our government had the power to effect the radical changes of 1991 with none of the tortuous process evident in America. But even more surprising to them was the direction of the change towards a more competitive health system in which the private sector would have a larger part to play. They asked for evidence of improved effectiveness and efficiency - I had to say that I knew of none so far. They asked how we would stop the better off leaving the public sector by increasing their medical insurance, thus beginning the slide to a two tier system. I was unaware of any plans to control the public-private balance in this way. They asked if we had the answer to escalating costs of health care and the rationing of diminishing resources. I was able to say that we do still have the mechanisms for a national policy and that the Core Committee could play an increasingly key role.

Will we succumb to the American dream and its consequent nightmare? Perhaps not, but there are signs of danger. In this issue **Grant Gillett** and **Barbara Nicholas** report how they have advised against putting a personal profit motive into general practice budget holding. It is a sign of the times that this ethical point has to be made. Also a sign of the times is the rising public anxiety about health care in the future. Perhaps I am over-sensitised now, but since my return I have been struck by the number of advertisements for private health insurance on television, and by the fears which these advertisements provoke in order to persuade people that they need more than public health care. My American friends would tell me that there are signs of a shift of power here that we should not ignore if we value our inheritance of universal health care irrespective of ability to pay. I wonder how we can keep our own dream.

Alastair V. Campbell
Director, Bioethics Research Centre

Commentary

Ethical Considerations in Budget Holding

Grant Gillett and **Barbara Nicholas**, Bioethics Research Centre

Around the country a number of General Practices are participating in budget-holding pilot projects. The basic idea is that a practice is contracted to provide a specified range of services within a budget determined by the number and type of patients, rather than the number of their visits. If the practice is able to provide adequate services on less than that budget then the extra funds could be used in some way by the practice concerned. Were the practice also to be held accountable, financially, for any overspending, then this would be a "risk-sharing" arrangement.

The budget holding initiative is devised within a context where it is accepted that there are limited health care funds available. In particular it accepts that health care funds should be "capped" in that their level should be set, and health care purchasers and providers should then work within that level. Ideally it aims to allow decisions about the use of a proportion of the health care funds available to be made at a more local level community practice rather than at the level of central agencies and planning bodies.

The Bioethics Research Centre was asked by the Southern Regional Health Authority (SRHA) to comment upon the ethical implications of such arrangements, and what follows summarises some of our major considerations [1].

Ethical issues
The *World Medical Association* states:

> A physician shall not permit motives of profit to influence the free and independent exercise of professional judgment on behalf of patients; and,

in the Declaration of Lisbon,

> The patient has the right to be cared for by a physician who is free to make clinical and ethical judgments without any outside interference.

These principles seem to many to imply that doctors cannot in any way ration the care offered to their patients. But this is an unrealistic stand because in any capped budget system, the decisions have to be made somewhere, whether in terms of a hospital waiting list, a local practice or somewhere else on the wider stage. In this respect a Budget Holding Practice (BHP) is no different from a hospital specialist or manager, or a doctor in a subsidised system where there are budgetary constraints. That said, one special concern about budget holding is that it may allow a shifting of responsibility for limited access to health care resources. If this happened, rationing decisions severely constrained by policies determined elsewhere would mistakenly be blamed on BHPs and the individual practitioners involved. This would provide a ready means whereby criticism of policies could be misdirected by laying the responsibility for choices in health care provision at the door of the individual practice or practitioner, who may be working within external funding constraints.

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Interested players
The interested players in health care expenditure are patients, primary caregivers, ancillary services, secondary care institutions (including both Crown Health Enterprises and Private Hospitals), and the Regional Health Authority. We must therefore consider the effects of budget holding arrangements on all of these groups. As far as patients are concerned, they may receive an enhanced access to