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.

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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

health care services as a result of the savings to be made. The primary care practitioners stand to gain more autonomy and professional satisfaction from assuming control over part of the funds they normally receive for their services. The ancillary services, laboratories and pharmaceutical suppliers, will have to work within a level of resourcing which is controlled by the practitioners ordering services. Therefore it will be likely in the short term they will see their funding levels restricted because of positive attempts to save money by those practitioners. Secondary providers such as hospitals, if included, will not be able unilaterally to decide how many interventions, both diagnostic and therapeutic, they provide but will have to develop a working relationship with the BHPs whose patients they are treating. RHAs stand to gain better accountability for the funds they disburse and the advantage of being able to introduce, at a strategic level, incentives which might contain the health care budget.

Is it worth doing?
Any administrative and monitoring procedure must be resourced, and, in the case of Budget Holding Practices, these resources come from the Health Care budget. We should note that a practice can only generate savings if assumptions are made that gains in efficiency and cost-effectiveness are possible without compromising care. One must also assume either that administration and management costs will be as they are in the present budget, or that any extra costs of management, administration, and transactions with other institutions are significantly less than the efficiency gains of becoming a BHP. These assumptions will need careful monitoring over the initial period of budget holding.

Who should keep the savings?
One of the implicit expectations of budget holding is that efficiency gains, and hence savings, will be made through practices having responsibility for their own budgets. There are three possibilities for the use of any savings: the professionals might keep them as personal income; the RHA might recover them for its own use; the patients of the practice making savings might receive additional services. We would argue that any system in which the budget holding group have, as individuals, a direct personal gain to be made from underspending their health care budget would tend to introduce distortions into the process of professional decision-making and therefore may have damaging effects on patient care. Even if this were not to happen the perceived fact that one's doctor stood to gain from providing less or cheaper modes of investigation and treatment could not help but damage the patient's confidence that he or she was receiving optimal care. Also we think it inappropriate for doctors, already paid for services provided, to make additional gain from the public health budget.

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On the other hand it would be counterproductive for the RHA to recover the savings. Practitioners would then be asked to take responsibility for administering or managing a budget as agents of the RHA, without being given any power to decide on use of the savings that they achieve, and with no guarantee that those savings will have the desired effects (in terms of enhanced access to care) for their patients. However, if the group practice is able to retain savings made then these can be used to provide easier access to care or additional and extra services over and above those explicitly required within the terms of the budget holding agreement. Given reasonable intent by the BHP group this should result in improved levels of service for the patient population of that practice. It may be that the specific nature of additional services would be jointly agreed through negotiation between the RHA and the BHP.

Risk sharing
Risk sharing clearly places responsibility for prioritising (and rationing) at GP level. While some measure of responsibility is already accepted and appropriate, extensive risk sharing at such a local level is questionable. The responsibility for the risk of blow-out is likely to introduce quite sinister incentives and distortions into the practice of some professionals, specifically those who do not feel able to put their own family and personal finances at stake in an exercise which could miscarry for reasons over which they have little control (such as unexpected demand, unrealistic funding levels, mistakes about actual levels of need, and so on).

At first sight the idea that a practice should keep their savings but not be penalised for overspending seems strange. But we should remember that the major incentives to practitioners within this system are not financial but professional, the possibilities it offers to enhance patient care through use of any savings made.

Is budget holding unfair?
Some argue that if BHPs are able to purchase, say, physiotherapy services from their savings where, in general, they are only available on a "user-pays" basis, this disadvantages patients of other practices in unfair ways. This is an odd objection because it implies that we cannot encourage efficiency in budget use because those whose budget is inefficiently used should set the standard for care. This is absurd, provided there is equal opportunity for all patients and all doctors to become involved in the more efficient arrangement.
Our abiding concerns are twofold:

a) Budget holding must not become an elaborate cover up for further contraction of the public health system by shifting apparent responsibility for restricted access to services from policy makers to primary care professionals.

b) Budget holding must not be abused by health professionals trying to get rich through transforming savings into personal profits (however disguised by companies or other commercial personae). In the development of new structures and methods for delivering healthcare it is important that the focus remains on delivering the best possible health care to patients and that it is patients who benefit from gains in efficiency and accountability.

[1] Copies of the full report can be obtained from Christine Crane, Southern Regional Health Authority, PO Box 5849, Dunedin.