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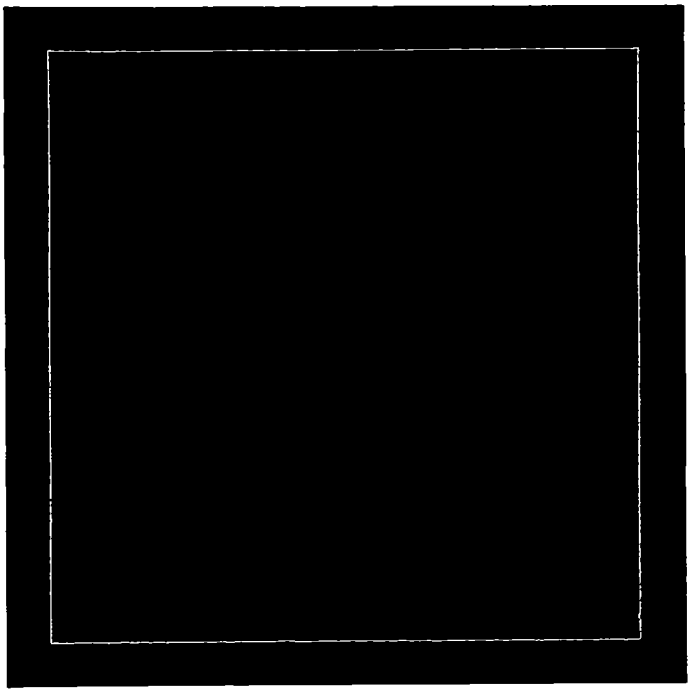



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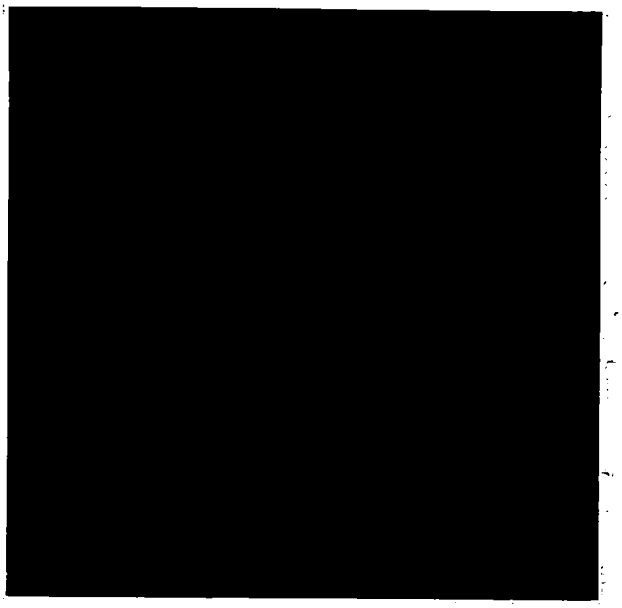

# RESOURCE CENTRE PAPER 1/90

# DISCUSSION PAPER

# ON

# PERSPECTIVES ON

# HEALTH SERVICES



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Health Services Resource Centre

# PERSPECTIVES ON HEALTH SERVICES

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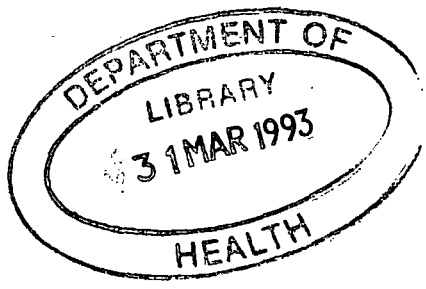

# PERSPECTIVES ON HEALTH SERVICES

TIM O'SULLIVAN

## INTRODUCTION

This paper examines major health service characteristics and objectives and the philosophy underpinning the development of the services in modern times. It places in that general context current discussion of health issues, particularly those relating to resource allocation. It examines changes in perspectives in the health services and attempts to assess the significance of such changes and their implications for the future. In general, the article emphasises the importance of the health services' deeply personal nature and Good Samaritan traditions, even at a time of severe cost pressures.

In recent decades, enormous advances in medical techniques and possibilities, growing concern about existing patterns of health expenditure and what amounts to an international crisis of public funding have pushed cost and resource allocation issues to the centre of public debate about the health services. Until a few

decades ago, as the OECD [1] noted in 1987, health services debate focused on medical progress and service expansion and on access to care. In recent times, however, the emphasis on debate has definitely shifted to cost-related issues and cost control.

On the international scene, cost-related pressures have contributed to a fundamental reexamination of issues like health services organisation and funding, the balance between institutional and community care or between public and private care, and the role of government in the health services.

In the present financial situation, all aspects of service organisation in Ireland and elsewhere have been open to question but it is arguable that there has been insufficient general reflection on the health services, on their objectives and philosophy, and on the implications of policy developments for those objectives or that philosophy. In the face of extreme cost

pressures, such reflection can seem like a luxury. Major recent reports have, however, strongly advocated the need for a more systematic reflection on the health services Health - The Wider Dimensions (1986)[2] advocated the need "to take more explicit account of the nature of contemporary health problems in framing policy" (par. 1). The Report of the Commission on Health Funding (1989)[3] noted (2.9) that decisions in the health services were often based on intuitive rather than objective criteria. A basic assumption in this article is that policy decisions need to be viewed in the light of overall health services objectives and that there is therefore a need for clarity about such objectives and about the fundamental values which ought to govern them. In the absence of such clarity, I argue here, immediate cost pressures can achieve an unhealthy dominance in thinking about the health services and in health services management. This article, then, emphasises the importance of a process of general reflection on the health services' objectives and philosophy, a process to which it also seeks to contribute.

## HEALTH SERVICES CHARACTERISTICS

In looking at health services characteristics, it is useful to distinguish between the structural characteristics of health services organisation and delivery and underlying characteristics relating more to the nature and objectives of the services.

Structural characteristics include the labour intensive and talent intensive nature of the health services, their round the clock dimension, their technological and organisational complexity and their cost. Another important structural characteristic is the influence and autonomy of health professionals, particularly doctors. Clinical autonomy is usually viewed either as guaranteeing preservation of trust and confidentiality between doctor and patient and the free exercise of professional skills; or, more negatively, as a barrier to effective administrative and resource allocation procedures.

Whether viewed positively or negatively, clinical autonomy is a fairly distinctive characteristic of management in the health services. Issues relating to the administration of professionals arise in other areas where there is significant professional involvement, e.g. local authorities and universities, but not in such developed form as in the health services.

Structural characteristics should not be seen in isolation from important underlying characteristics of health services, and especially their distinctively personal nature. The health services are personal in a number of senses:

(a) His or her health is deeply central to every person

(b) The services are provided by persons to persons

(c) Each person is different so that while the services themselves may be socialised, medical and nursing care cannot of their very nature be mass-produced like consumer goods or services.

On this last point, Stacey (1976)[4] argues that if in a sense the patient is a "consumer", "he is at the same time a work object. A patient of the health service offers his body and his person as a work object" (p 195).

A person buying a fridge and another undergoing a heart operation can both be called "consumers" but the underlying human reality is very different. In the second case, for one thing, as well as being the "consumer" of the service, the heart patient is also the "object" of the care being carried out. Rather than seeing the patient as a "consumer", Stacey views him "as partner but also as work object" (p 200) and suggests that the health service should be thought of as a process of "more or less prolonged interaction between the minds and bodies of the patients and the health care workers" (p 196).

## HEALTH SERVICES OBJECTIVES

Largely because of the strong personal dimension outlined above, health services objectives are broad based, open-ended and more difficult to define precisely than in other spheres. If establishment of objectives is difficult, then evaluation, or the measurement of success in meeting those objectives, is also difficult. The Commission on Health Funding summarises the difficulties involved as being (a) that of measuring health and (b) that of measuring the effects of healthcare on health (5.4). Progress has been made recently in attempting to evaluate health

services performance but this difficulty of measurement distinguishes the health services from the business world, for example, where objectives are usually easier to set.

The Commission on Health Funding identified two 'fundamental precepts' in health i.e. that necessary health services should be available to all persons on the basis of their need for such services and not on their ability to pay and that the costs of such services should be shared on the principle of proportionately greater contributions from those of greater means (6.18). The Commission also identified comprehensiveness, cost effectiveness and equity as important criteria for the evaluation of public health services (5.1).

A brief definition of health services objectives is provided by McKeown (1979)[6] who describes them as being 'the prevention of sickness and premature death and the care of the sick and disabled'. Though views may differ on the adequacy of this response, the health services respond, by definition, to the

health needs and disease or disability problems which exist or are perceived in any community. As needs change, the services change. Thus in developed countries, the health services and health policy have obviously responded over the past century to the health changes which have taken place in those countries during that period e.g. the decline in infectious diseases, the increased prevalence of heart disease and various cancers. Health itself, ideas about health and health services trends and objectives, are also all influenced by wider economic and social developments. Improvements in economic conditions, for example, generally improve health, increase health expectations and enable more resources to be devoted to health services.

The relationship between the health services and health is not simple. Major influences on health such as nutrition, behaviour and the environment, are outside the health care system, at least as traditionally defined; and some important influences on health policy, e.g. the influence of various interest groups, may have relatively little to do with health needs per se.

MODELS OF HEALTH AND DISEASE

It is clear that health service objectives are linked, though in a complex way, to health and to ideas about health. There are several different approaches to, ways of understanding or "models" of health and disease. One of the principal models is what is usually called the "medical", disease or "cure" model which concentrates on the disease experience of the individual patient and places emphasis on the provision of curative and particularly of hospital services for him and on his rapid re-integration into normal working and social life.

A second important model, the welfare or "care" model, assumes that most diseases have psychological or social as well as more strictly medical origins. It also highlights the traditional neglect of certain non-curative services e.g. the long-term "caring" services for the chronically ill or the elderly. This model emphasises the importance of the prevention or relief of suffering and of seeing the patient as a whole person rather than simply as a medical case.

The cure and care models are linked in their emphasis on the individual but a more collective approach to health services focuses on society rather than on the individual. This model suggests that improvements in health will only come through improvements in housing, the environment, prevention and so on. In this view, the provision of curative health services can achieve relatively little in the absence of wider social reform or improved prevention.

The terminology used here is clearly not sacrosanct but these categories do correspond to three major models of health and disease. They have been sharply drawn here for the sake of clarity but may not be so clear cut in practice. While all three models may be reflected in a particular pattern of health services organisation, the medical, hospital-oriented model is usually of primary importance.

Criticism of the "medical model" of health and disease, while strongly influenced by concern about hospital costs, has also developed from a recognition of limits to the improvements in health which medical technology can bring. Medical specialists

themselves recognise that such technology has, in many instances, (e.g. cancers of various types) achieved more in the area of diagnosis than in that of therapy. Writers like Illich (1977)[5] have gone beyond the idea of limits to medicine to put forward the view that much illness is iatrogenic i.e. caused by medical intervention.

The thesis of Thomas McKeown in "The Role of Medicine", (1979)[6] is that the medical model, with its focus on the clinical care of patients who require investigation and treatment and its relative neglect of preventive services and of services for the "chronically" ill, rests on the belief that health depends primarily on intervention in disease processes. The history of developed countries in the last four centuries points, however, in McKeown's view, to nutrition, behaviour and the environment as much more fundamental determinants of morbidity than medical factors per se.

The dissatisfaction which has developed with the medical model also reflects a feeling that health, disease and disability are extremely complex concepts; that strictly medical classifications and definitions, while important, are not sufficient; and that

psychology and sociology also have a role to play in the establishment of definitions in the health and disease area. In the area of disability, Blaxter has pointed out that an individual's position on the health-disability continuum depends on many factors. These include how the disability is identified and perceived by society, by medical science and by the relevant administrative authorities. They include, too, the individual's social and family environment and personality. (Cox and Mead eds. 1975)[7].

If the understanding of health and disease offered by an exclusively medical model seems too narrow, broad definitions of health also have their problems. While noting that concepts of health and illness are complex and definitions difficult to make, Reidy (1978)[8] also suggests that if definitions of health and illness are very broad, it may become difficult to distinguish between the two. And if they are very broadly defined, there is a risk that all human difficulty may be seen as a health problem or as a kind of sickness. By a curious paradox, dissatisfaction with the medical model would thus lead to an increased role for medicine. Problems that are human rather than medical might then look to medicine for their solution. This idea, which may be

linked to Illich's attack on the medicalisation of life, calls into question the very broad WHO definition of health as a state of complete physical, mental and social well-being.

## RESHAPING OBJECTIVES IN IRELAND

As suggested above, questions such as what are the health services trying to achieve? what are their objectives? are closely linked to ideas about, and models of, health and disease. Thus the broadening of ideas about health in recent years has led to a re-shaping of objectives and patterns of service: official thinking about health services has moved generally from emphasising curative medicine and centres of excellence to stressing prevention, health education and primary care.

A good example of such new thinking in Ireland came in the Department of Health statement, Health - The Wider Dimensions:

'Health policy over the past two decades has tended to emphasise the role of curing and caring, involving a rapid development of the acute general hospital system and a significant reliance on high technology medicine ... the direction being taken by the

current health system is more consistent with one which sees as its objective the provision of an efficient repairing service for damaged health rather than one which promotes positive health' (1.3).

The document went on to emphasise the need, and the cost justification for, 'the development of a more positive attitude to health and the re-shaping of health services to bring about a more appropriate balance between prevention, cure and care' (1.3).

Health - The Wider Dimensions also notes that basic tenets of the WHO's Health for All Programme include the removal of inequalities in health; an emphasis on health promotion and prevention of disease; and active community participation in developing strategies for health. In line with WHO guidelines, Health - The Wider Dimensions identifies four broad dimensions -- those might also be seen as four broad aims - of a positive health policy. These were: to ensure equity in health; to add life to years; to add health to life; to add years to life.

A broad consensus has developed in many countries around this policy. This consensus has undoubtedly led to greater spending in absolute terms on health education and primary care. Thus, new ideas about health clearly have influenced patterns of service provision.

On the other hand, spending on non-hospital services has not tended to increase greatly in relative terms. OECD figures (1987) suggest that although acute hospitals are under major financial pressure, the share of the budget taken by institutional spending has, in fact, increased internationally in recent years i.e. from 50.9% of the total in 1970 to over 53% in the early 1980s.

A number of factors need to be taken into account here, including the cost of high-technology hospital care and the difficulty involved in changing existing patterns of resource allocation. There is, too, the fact that many current major diseases (heart diseases, cancer, cerebrovascular diseases etc.) are associated with a certain lifestyle; that improvements in lifestyle will take many years to be reflected in improved mortality statistics;

and that the morbidity produced currently by the major diseases provides a strong rationale for the continued emphasis on hospital services, for which there is also strong public demand. Critics of high hospital spending also suggest that existing organisational patterns and professional interests impede significant changes in existing patterns of service provision. Whatever explanation is preferred, it is obviously easier to change objectives in theory than to re-shape services in practice.

## HEALTH SERVICES PHILOSOPHY IN AN ERA OF COST PRESSURES

Reidy (1978) notes that our concepts of health and disease are related to our more general ideas about the nature and purpose of the human person. Perspectives about the health services and their objectives depend ultimately on perspectives about people. Though their history is obviously complex, modern health and welfare services are rooted in a basic philosophy of reverence for life and respect for the dignity of each person who is served; a philosophy which underpins in different ways all three "models" of health and disease discussed above. Respect for persons, indeed, is a basic value on which the welfare state is

built. To refer to this philosophy is not to assert that it is always well reflected (or indeed easy to reflect) in day-to-day practice but rather it has strongly shaped the historical development of the health services in the modern world.

In recent decades, this traditional philosophy of reverence for human life in all conditions and circumstances has come under increasing challenge and examination. The marked decline in respect for human life at its beginning and end may be noted in this context. Referring to philosophical changes taking place in the health services and society, an editorial in an influential American journal, California Medicine[9] , stated twenty years ago that the traditional Western ethic had always placed great emphasis on the intrinsic worth and equal value of every human life regardless of its stage or condition; but that this value was being eroded at its core by a tendency to place relative rather than absolute values on human lives and by a new emphasis on the quality of life.

The fundamental moral questions - sometimes described as bioethical issues-which face society as a whole are outside the scope of this paper. Nevertheless, within a narrower health

service context, cost pressures and new perspectives on health services objectives and priorities have led to re-examination of the basic values and raison d'etre of the health serviecs. Within those services philosophical issues relating to relative and absolute values have appeared, notably in the attempts to value life made by philosophers or economists. In an Irish context, an economist Tussing, (1985)[10] has outlined the philosophy underlying one economic approach to resource allocation in the health services.

Society, he argues, places an implicit value on human life, a value which is observed by economists to be relative rather than absolute: "If we ask how many lives per year can we save if we improve a dangerous turn in a highway or buy a new ambulance... and if we decide on the basis of such calculations (to accept or not the necessary expenditure) we are implicitly placing a value on an abstract human life". (p.34)

There is, he says, an extraordinary range of implicit values placed in the health services on a human life. In particular, society values the known individual (e.g. in an emergency situation) over the unknown person. This preference is in

conflict with economic efficiency i.e. the health service spends a lot of money in prolonging for short periods of time the lives of certain patients with poor prognosis while other parts of the service are unable to provide adequate care for all who need it. According to Tussing, economists regard the behaviour of society toward the abstract anonymous person as an accurate indicator of the relative value placed by society on human life generally.

His argument, in effect, is for more efficient resource allocation leading in turn to "welfare maximisation" in the health services and in society: if society's valuation of life can be worked out, it should also be possible to calculate the expenditure which it is appropriate to make in any particular area of medicine in order to save life.

One point which emerges from this analysis is that resource allocation debates, which can seem matters of technical detail, may raise profound philosophical issues. Thus studies which attempt to give a relative value to human life or to report on what is seen as society's valuation have considerable philosophical significance and are open to challenge on philosophical grounds. In an analysis criticising contemporary

life valuation theory, Burtchaell strongly opposes the view that any human beings have merely a relative value. He argues that human beings are not valuable at all. Rather, he says, they are invaluable or beyond value. He continues that we owe things of value to persons who are beyond value and suggests that it is the least "valuable" persons in a utilitarian sense - e.g. the handicapped - who actually have the strongest claim on us.

The problem of limited resources and apparently unlimited human needs is viewed as follows by Burtchaell: "In matching our resources to our neighbours' needs, we are presented with a most rudimentary moral option: whether to exert ourselves to meet these endless neighbour - needs or whether to adjudicate these needs and claims to serve our pleasure by calculating their social benefit potential". Burtchaell asks whether our focus is on meeting people's needs or on the costs and benefits involved in treating particular patients. The implication of this argument is that economic rationality, cost control and medical progress, although important, are means rather than ends. Human beings, on the other hand, are ends rather than means. They have an absolute value in the health services as well as elsewhere in society and ought to be treated accordingly. Thus the dedication

of doctors, he suggests, ought not to be to human life as such "but to human beings whose lives we heal if we can but still serve if we cannot" (pp 54-63)[11].

No argument about the primacy of the person can afford to ignore the reality of limited resources, the necessity for difficult and detailed resource allocation decisions or the importance of economic techniques and analyses in the health service. An Irish Minister for Health has argued that there are 'two parallel imperatives' in the health service: "the patient comes first and cost effective efficiency is essential"[12]. What this paper suggests is that there are dangers in the general international shift in the focus of debate from the necessity of meeting patients' needs to cost related issues and choices. More specifically, if there is an over-emphasis on costs and benefits, the human being at the centre of the service may come to be seen as merely a means to the end of cost control or economic efficiency. In that context, the health service is likely to be seen almost exclusively as a large, complex system inhabited by competing interest groups rather than primarily as a service of persons to persons, or one in which the patient comes first.

## CONCLUSION

Perspectives on, and debate about, the health services in Ireland and elsewhere have focused in recent years on cost issues and on the grave problems caused by unprecedented cut-backs in health expenditure. Very speedy, significant and painful action has been demanded to effect the savings imposed by cut-backs.

In this climate, general reflection on the aims and underlying values of the health services can be viewed as something of a luxury. This paper has argued, however, that there cannot be a coherent approach to cost containment or a just system of resource allocation in the absence of a clear general understanding of the objectives and philosophy of the health services. There must, for example, be clarity about means and ends. Efficient cost containment is not an end in itself but rather a constraint within which services are provided or a means towards the end of a humane service. If cost control were seen as the ultimate goal, there would be a danger of an unacceptable decline in the quality of services generally and especially those for less influential groups.

This reflection on health services has also pointed to the distinctively personal nature of those services, to the fact that the services are provided by persons to persons. Significant depersonalising trends are evident in the health services as elsewhere in society. What I have argued here is that if the human being is to remain at the centre of the health services, if depersonalisation is to be avoided, a deeply personal understanding of the services needs to be emphasised and safe-guarded.

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