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Priority Setting in Public and Private Health Care

A Guide Through the Ideological Jungle

by ALAN WILLIAMS

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A GUIDE THROUGH THE IDEOLOGICAL JUNGLE

by

Alan Williams

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The Author

Alan Williams is Professor of Economics at the University of York.

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Abstract

Priority setting reflects ideology, and so, more surprisingly, does the quest for "efficiency". A great deal of the current debate about alternative methods of finance and about reform of management structures, in health services all over the world, purports to be about some notion of efficiency which it is believed we all seek. But efficiency depends on objectives. How important is freedom of choice, what weight is to be given to "need", how much innovative diversity is compatible with equality of access? This paper presents two polar ideological positions, and outlines the kind of health services each holds up as "ideal"? It is argued that neither ideal is seen in practice, but our views as to what would make a real-world health service more "efficient" will depend on which ideal we wish it to move towards. But is there any ideologically coherent middle ground which would justify a mixed system. A mixed system is a muddle, but is it a muddle we have chosen (and can therefore justify), or is it the unintended by-product of intellectual confusion? This discussion paper is intended to help its readers identify, and come to terms with the consequences of, their own ideology, so that the debate about the merits of rival systems is not conducted on a false appreciation of which issues are "factual" and which are "ideological".

PREAMBLE

Priority setting means deciding who is to get what at whose expense. In the context of health care, the "what" in that statement refers to different sorts of health care, and the "who" to different sorts of people. The "whose expense" is not so straightforward. It appears to refer to "who will pay the bill", and in a public health care system this might seem to be the government, though behind the government stands the taxpayer, and that means all of us. Even in a private health care system it is rarely the patient who meets the bill directly, for some or all of it will be met by an insurer, and the costs of any particular treatment episode will be spread over many premium-payers. But in the context of an economic, rather than a financial, analysis the phrase "at whose expense" has to be interpreted in a different way, based on the notion of opportunity cost, rather than on the notion of expenditure. When so reinterpreted, it means "who is to go without" health care in order that others shall have it. Giving priority to one group of people means taking it away from another group, though for obvious reasons politicians tend not to dwell on this implication, leaving us to infer, from what is not said, who the "low priority" groups are. In any honest and open discussion of these issues, however, that implication must be faced squarely, and we must not shrink from identifying who (implicitly) the "low priority" people are, in any particular system of health care.

INTRODUCTION

Priority setting reflects ideology, so we must start by analysing the characteristic ideologies of public and private health care systems. Both systems (and their respective ideologies) have then to face the problem

that the recent rapid growth of effective health care has led us to the point where no country (not even the richest) can afford to carry out all the potentially beneficial procedures that are now available, on all the people who might possibly benefit from them. So priority setting can no longer simply be a matter of eliminating ineffective activities (i.e. it is now more than a matter of becoming more efficient in the low-level sense of getting onto the production possibility frontier). Priority setting now has to deal with the much more contentious high-level efficiency problem of choosing where to be on the production possibility frontier, that, which mix of (efficient) activities to select from those that are open to us. This is a matter of allocative efficiency rather than technical efficiency, inevitably contains equity considerations (i.e. views as to how the welfare of one person is to be weighed against the welfare of another person). That is why the ideological content has to be made explicit and given prominence, which is the content of the next Section of this paper.

I shall then proceed from ideology to "pure" private and "pure" public systems and the characteristic problems they each encounter. This will lead naturally to a consideration of "mixed" systems, in which each adopts a little of the other in order to reflect the pluralist ideologies of the communities they serve. This inevitably generates muddle, and brings us closer to the systems we actually see operating around us, and which we are struggling to understand and "improve". This brings us finally to the appraisal of policy making and performance in the different systems, and to the question whether there is an overall framework within which we can decide which is the best system of health care. I shall conclude that it all depends on your priorities.

IDEOLOGY AND OBJECTIVES

The ideological issues in the provision of health care have been admirably dissected by Donabedian (1971), in which he polarises attitudes around two viewpoints, "A" and "B", which may be loosely termed the "libertarian" and the "egalitarian" respectively. In the libertarian view, access to health care is part of the society's reward system, and, at the margin at least, people should be able to use their income and wealth to get more or better health care than their fellow citizens should they so wish. In the egalitarian view, access to health care is every citizen's right (like access to the ballot box or to the courts of justice), and this ought not to be influenced by income or wealth. Each of these broad viewpoints is typically associated with a distinctive configuration of views on personal responsibility, social concern, freedom and equality, which are set out in summary form in Table I.

The implications of each of these ideologies for priority-setting in health care are pretty obvious. Willingness and ability to pay should be the dominant ethic in the libertarian system of health care provision, and this can best be accomplished in a market orientated "private" system (provided that such markets can be kept competitive). Equal opportunity of access for those in equal need should be the dominant ethic in the egalitarian system of health care provision, and because such a system requires a social hierarchy of need to be established which is independent of who is paying for the care, it dictates public provision (provided that such a system can be kept responsive to social values and changing economic circumstances). Let us look at each such system in more detail.

TABLE I: ATTITUDES TYPICALLY ASSOCIATED WITH VIEWPOINTS A AND B

	Viewpoint A (Libertarian)	Viewpoint B (Egalitarian)
Personal Responsibility	Personal responsibility for achievement is very important, and this is weakened if people are offered unearned rewards. Moreover, such unearned rewards weaken the motive force that assures economic well-being, and in so doing they also undermine moral well-being, because of the intimate connection between moral well-being and the personal effort to achieve.	Personal incentives to achieve are desirable, but economic failure is not equated with moral depravity or social worthlessness.
Social Concern	Social Darwinism dictates a seemingly cruel indifference to the fate of those who cannot make the grade. A less extreme position is that charity, expressed and effected preferably under private auspices, is the proper vehicle, but it needs to be exercised under carefully prescribed conditions, for example, such that the potential recipient must first mobilise all his own resources and, when helped, must not be in as favourable a position as those who are self-supporting (the principle of "lesser eligibility").	Private charitable action is not rejected but is seen as potentially dangerous morally (because it is often demeaning to the recipient and corrupting to the donor) and usually inequitable. It seems preferable to establish social mechanisms that create and sustain self-sufficiency and that are accessible according to precise rules concerning entitlement that are applied equitably and explicitly sanctioned by society at large.
Freedom	Freedom is to be sought as a supreme good in itself. Compulsion attenuates both personal responsibility and individualistic and voluntary expressions of social concern. Centralized health planning and a large governmental role in health care financing are seen as an unwarranted abridgement of the freedom of clients as well as of health professionals, and private medicine is thereby viewed as a bulwark against totalitarianism.	Freedom is seen as the presence of real opportunities of choice; although economic constraints are less openly coercive than political constraints, they are nonetheless real, and often the effective limits on choice. Freedom is not indivisible but may be sacrificed in one respect in order to obtain greater freedom in some other. Government is not an external threat to individuals in the society but is the means by which individuals achieve greater scope for action (that is, greater real freedom).
Equality	Equality before the law is the key concept, with clear precedence being given to freedom over equality wherever the two conflict.	Since the only moral justification for using personal achievement as the basis for distributing rewards is that everyone has equal opportunities for such achievement, then the main emphasis is on equality of opportunity; where this cannot be assured the moral worth of achievement is thereby undermined. Equality is seen as an extension to the many of the freedom actually enjoyed by only the few.

PURE SYSTEMS AND THEIR PROBLEMS

A simple view of these two systems would run something like this: (a) in a private system, access is determined by willingness and ability to pay, and producers are kept responsive to consumers' demands by the profit motive, and things are held in balance by price adjustments in competitive markets; whilst (b) in a public system access is determined by need, to which producers are kept responsive by the humanitarian motive, and things are held in balance by quantity rationing based on a socially approved system of rules. A rather more complex specification of the characteristics of each such idealised health care system is given in Table II, which is taken from Maynard and Williams (1984).

The basic weakness of the idealised view of both of these systems is the peculiar "agency" role which doctors play in all health care systems. The essence of this problem is that the "consumers" rely on doctors to act as their agents, in a system which ostensibly works on the principle that the doctor's role is to give the patient all the information the patient needs in order to enable the patient to make a decision, and the doctor should then implement that decision once the patient has made it. I am sure that the reader would find the above statement closer to his or her own experience if the postulated roles of patient and doctor were interchanged, so that the sentence would then read "the patient's role is to give the doctor all the information the doctor needs in order to enable the doctor to make a decision, and the patient should then implement that decision once the doctor has made it".

Once the doctors are acknowledged not to be "perfect agents", but, through the exercise of "clinical freedom", may be pursuing interests other

TABLE II: IDEALISED HEALTH CARE SYSTEMS

	Private	Public
Demand	1 Individuals are the best judges of their own welfare.	When ill, individuals are frequently imperfect judges of their own welfare.
	2 Priorities determined by own willingness and ability to pay.	Priorities determined by social judgements about need.
	3 Erratic and potentially catastrophic nature of demand mediated by private insurance.	Erratic and potentially catastrophic nature of demand made irrelevant by provision of free services.
	4 Matters of equity to be dealt with elsewhere (e.g. in the tax and social security systems).	Since the distribution of income and wealth unlikely to be equitable in relation to the need for health care, the system must be insulated from its influence.
Supply	1 Profit is the proper and effective way to motivate suppliers to respond to the needs of demanders.	Professional ethics and dedication to public service are the appropriate motivation, focusing on success in curing or caring.
	2 Priorities determined by people's willingness and ability to pay and by the costs of meeting their wishes at the margin.	Priorities determined by where the greatest improvements in caring or curing can be effected at the margin.
	3 Suppliers have strong incentive to adopt least-cost methods of provision.	Predetermined limit on available resources generates a strong incentive for suppliers to adopt least-cost methods of provision.
Adjustment mechanism	1 Many competing suppliers ensure that offer prices are kept low, and reflect costs.	Central review of activities generates efficiency audit of service provision and management pressures keep the system cost-effective.
	2 Well-informed consumers are able to seek out the most cost-effective form of treatment for themselves.	Well-informed clinicians are able to prescribe the most cost-effective form of treatment for each patient.
	3 If, at the price that clears the market medical practice is profitable, more people will go into medicine, and hence supply will be demand responsive.	If there is resulting pressure on some facilities or specialties, resources will be directed towards extending them.
	4 If, conversely, medical practice is unremunerative, people will leave it, or stop entering it, until the system returns to equilibrium.	Facilities or specialties on which pressure is slack will be slimmed down to release resources for other uses.
Success criteria	1 Consumers will judge the system by their ability to get someone to do what they demand, when, where and how they want it.	Electorate judges the system by the extent to which it improves the health status of the population at large in relation to the resources allocated to it.
	2 Producers will judge the system by how good a living they can make out of it.	Producers judge the system by its ability to enable them to provide the treatments they believe to be cost-effective.

than those of the patient in front of them (Williams, 1984), then each system manifests a characteristic bias. Private systems tend to "oversupply" health care in areas of practice where doctors have plenty of discretionary power and where it is advantageous to them to do so, and public systems tend to "undersupply" health care procedures where doctors have plenty of discretionary power and where it is advantageous for them to do so. More specifically, in Table III the implications for each of the points made in Table II are set out in more detail, permitting an item-by-item comparison of the "actual" versus the "idealised" characteristics of each system.

We then find ourselves in a paradoxical situation. The private system, which generates strong incentives for cost-minimisation at the micro level, faces a severe problem of cost-containment at macro level because of its inability to control quantities supplied. Conversely, a tax financed public with prospective budget limits has no problems over cost-containment at macro-level, but severe problems in generating cost-consciousness at micro-level, due to the absence of appropriate low level financial incentives. It is, therefore, hardly surprising that a solution is sought in a mixed system which might hopefully combine the best of each "pure" system.

MIXED SYSTEMS AND THEIR PROBLEMS

In principle there are several different ways in which systems may be "mixed". One could have a single system with "mixed" motives. Or one could have two pure systems operating independently side by side serving the same community, with neither playing a dominant role. Or one could

TABLE III: ACTUAL HEALTH CARE SYSTEMS

	Private	Public
Demand	1 Doctors act as agents, mediating demand on behalf of consumers.	Doctors act as agents, identifying need on behalf of patients.
	2 Priorities determined by the reimbursement rules of insurance funds.	Priorities determined by the doctor's own professional situation, by his assessment of the patient's condition, and the expected trouble-making proclivities of the patient.
	3 Because private insurance coverage is itself a profit seeking activity, some risk-rating is inevitable, hence coverage is incomplete and uneven, distorting personal willingness and ability to pay.	Freedom from direct financial contributions at the point of service, and absence of risk-rating, enables patients to seek treatment for trivial or inappropriate conditions.
	4 Attempts to change the distribution of income and wealth independently, are resisted as destroying incentives (one of which is the ability to buy better or more medical care if you are rich).	Attempts to correct inequities in the social and economic system by differential compensatory access to health services leads to recourse to health care in circumstances where it is unlikely to be a cost-effective solution to the problem.
Supply	1 What is most profitable to suppliers may not be what is most in the interests of consumers, and since neither consumers nor suppliers may be very clear about what is in the former's interests, this gives suppliers a range of discretion.	Personal professional dedication and public spirited motivation likely to be corroded and degenerate into cynicism if others, who do not share those feelings, are seen to be doing very well for themselves through blatantly self-seeking behaviour.
	2 Priorities determined by the extent to which consumers can be induced to part with their money, and by the costs of satisfying the pattern of 'demand'.	Priorities determined by what gives the greatest professional satisfaction.
	3 Profit motive generates a strong incentive towards market segmentation and price discrimination, and tie-in agreements with other professionals.	Since cost-effectiveness is not accepted as a proper medical responsibility, such pressures merely generate tension between the 'professionals' and the 'managers'.
Adjustment mechanism	1 Professional ethical rules are used to make overt competition difficult.	Because it does not need elaborate cost data for billing purposes, it does not routinely generate much useful information on costs.
	2 Consumers denied information about quality and competence, and, since insured, may collude with doctors (against the insurance carriers) in inflating costs.	Clinicians know little about costs, and have no direct incentive to act on such information as they have, and sometimes even quite perverse incentives (i.e. cutting costs may make life more difficult, or less rewarding for them).
	3 Entry into the profession made difficult and numbers restricted to maintain profitability.	Very little is known about the relative cost-effectiveness of different treatment, and even where it is, doctors are wary of acting on such information until a general professional consensus emerges.
	4 If demand for services falls, doctors extend range of activities and push out neighbouring disciplines.	The phasing out of facilities which have become redundant is difficult because it often threatens the livelihood of some concentrated specialised group and has identifiable people dependent on it, whereas the beneficiaries are dispersed and can only be identified as 'statistics'.
Success criteria	1 Consumers will judge the system by their ability to get someone to do what they need done without making them 'medically indigent' and/or changing their risk-rating too adversely.	Since the easiest aspect of health status to measure is life expectancy, the discussion is dominated by mortality data and mortality risks to the detriment of treatments concerned with non-life threatening situations.
	2 Producers will judge the system by how good a living they can make out of it.	In the absence of accurate data on cost-effectiveness, producers judge the system by the extent to which it enables them to carry out the treatments which they find the most exciting and satisfying.

have one system dominant, and the other playing a deliberately circumscribed role.

In a single system with mixed motives, there would be some areas of health care provision in which "need" was the only acceptable way of ordering priorities, and others in which "willingness-and-ability-to-pay" was the only acceptable way. For instance, access to all hospital treatment might be determined by need, but access to all primary care by willingness and ability to pay (or vice-versa). The problem with this sort of solution is that there is no clear line to be drawn between the two (people resort to casualty departments of hospitals in the absence of suitable primary care), and primary care usually acts as a first-line-of-investigation and as a "filter" for access to hospital care, so it is difficult to run each on a different principle and emerge with an overall system which makes sense. The same applies if one tries to separate "amenity" aspects of care (e.g. the "hotel" aspects of hospital care) from the "clinical" aspects (e.g. the nature of the operation or the drugs used). Clearly nursing care is partly clinical, partly "amenity", so levels and type of nursing attention could be counted either way at the margin. Such a unified but dual-principle system would also have to decide whether waiting time was a matter of clinical priorities (and therefore the same for everybody) or of amenity (so that those willing and able to pay should get the dates/times for treatment that suit them best). Trying to cope with these conflicts within a single organisation would seem to be rather a horrific task.

This brings us to the type of mix which consists of two freely competing independent systems operating alongside each other. A critical issue here will be whether everyone has to contribute to the costs of the

public system, whether they use it or not, and the scale on which the public system is financed. Generally the better off people will opt out of the public system, unless its standards are higher than those of the private system, so the outcome depends on how good the public system is. If doctors can make more money in the private than in the public systems, they will be drawn in that direction, and may even have an incentive not to have the public system perform too well in the areas where private practice is lucrative. The same incentive applies to the consumers in the private system, especially if the richer people are forced to contribute to the public system, since they will wish to have their public system contributions kept to a minimum (by keeping standards low) if they do not intend to use the public system anyway. It is, therefore, hard to see how two such different systems could operate side-by-side on anything like equal terms without leaving all parties feeling somewhat disgruntled.

Perhaps this is why most actual systems gravitate towards becoming mixed systems of the third type, within which one system predominates, and the other is permitted a minor, carefully circumscribed, role. Thus predominantly private systems moderate the ruthlessness of the "if you can't pay, you can't have" rule by organising a small public system to take care of the poorer people (including the "medically indigent", i.e. those who have run out of privately-insured entitlement and have no other financial resources to draw on). Such public systems are usually inferior in standards to the dominant private system (for if they were not, who would use the private system?). Conversely, a predominantly public system will moderate the ruthlessness of the "if you don't need, you can't have" rule by permitting a small private system to take care of the richer people (and any non-citizens who may have no entitlement to access to the public system). Such private systems may be better or worse clinically than the public system, but they will certainly offer standards of convenience and

amenity in excess of those offered by the public system (otherwise who would use the private system?). Both of these mixed systems could be viewed as representing an acknowledgement that the "dominant" ideology is not held by everyone in that society, and that the views of the minority must be respected and catered for, though only to a limited extent.

POLICY MAKING AND APPRAISAL

As has been stressed earlier, each system has its own characteristic ideology, and this generates an equally distinctive culture. In the private sector the "culture" is that of accounting and business management, the appraisal techniques are based on financial analysis and control, and organisational forms reflect the varying strengths and nature of the profit motive, as moderated by insurance markets. In the public sector the culture is that of economics and politics, the appraisal techniques based on cost-benefit analysis, and the organisational forms turn on varying patterns of centralisation or decentralisation within a (quasi) governmental framework. The private system will be held to be successful if it is profitable (but not <u>too</u> profitable?) and if it meets the varied demands of those with the most purchasing power. The public system will be held to be successful if it meets the needs of the sick at low cost (without too great a tax burden?). This brings us back to the paradox about cost-containment and efficiency mentioned earlier, and poses the question whether there is not some mixed <u>organisational</u> form which would enable each (pure) system to meet <u>its</u> objectives better.

Thus in the private systems there are attempts to develop better insurance mechanisms to help the (poor) needy by wider risk spreading, and to change the nature of the reimbursement mechanisms to give doctors an

incentive not to intervene "excessively" (Enthoven, 1985). Conversely, in the public systems there is an attempt to introduce more decentralised budgeting systems which give clinicians a strong incentive to minimise costs and direct the resources under their (effective if not nominal) control towards those activities which improve people's health most per unit of resource used (Williams, 1985). In this sense one can see an organisational "convergence" between the two systems which does not necessarily reflect any ideological" convergence.

My own view is that Donabedian was right to polarise the ideological differences between libertarians and egalitarians, and to emphasise the differences in view about priorities which such ideological differences generate. Each of us must decide for ourselves where we stand in that particular configuration of attitudes, and be honest with ourselves and with others about it. In case it is not already obvious from what I have already written in this paper, I feel quite strongly egalitarian, and would aim to make the public system stronger and the private system weaker, in any community on which I depended for health care. But I also recognise the need, in a democratic country, to respect the ideological position of a minority, provided it is not actually subversive. The trouble with private systems, in my view, is that they become "subversive" if permitted to play a significant role in a mixed system, because public systems rely on strong feelings of social solidarity (the rich must help the poor, the healthy the sick, the wise the foolish, the well-informed the ignorant, and so on), whereas private systems exist precisely to enable the rich, healthy, wise and well-informed to "opt out" and look after themselves. Thus there is a dilemma for muddle-headed people like me in deciding how far such tolerance can go.

It is not my role here to persuade you to adopt my view, but merely to identify the ideological dilemma as acutely as possible. Although I think that each system has something to learn from the other managerially, in the end each has to be judged according to its own lights, i.e. according to its own ideology. If we can make changes which rate well from both standpoints, well and good, but I observe that many supposed "improvements" in "efficiency" contain implications for priority setting in health care which seem to me to have a quite strong (though implicit) ideological component, and which I would therefore feel bound to reject because of their distributional implications. It is no solution to say to an egalitarian like me that the public system would be better if it adopted the priorities of the private system, and I would not expect to convince a libertarian that the private system would be better if it became more egalitarian (though that is what I believe). So, when appraising policy proposals for improving each respective system, let us state clearly whether our judgements flow from a basically libertarian or egalitarian stance.

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