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Keep Politics Out of Health!

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KEEP POLITICS OUT OF HEALTH!

by

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An interesting insight into these subcultures can be gleaned from Henric Hultin's* classification, which is presented in a slightly modified form in Table I, and really requires no further explanation.

Hultin comments:

"All three groups of actors are used mainly to do their own work each by themselves ... However, they are now forced to take part in the problems of each other, and co-operate in a way for which they have no rules. The co-operation is made more difficult by the fact that they are representing different cultures'".

I think a fourth distinct sub-culture needs to be added to the 3 identified by Hultin, namely that of the accountant. Its corresponding characteristics are respectively:

Education/Career	Uniform, narrow
Principals	Health Authority Accounting Profession
Guiding principles	Systematic Order Principles
Working organisation	Functional specialisation
Working forum	Arithmetic Budgets Audit

It will be noted that, though it shares more characteristics with the administrative subculture than with either of the others, it differs from it in some significant respects, and derives its power from insisting on functional specialisation, which is designed to shroud finance with an air of mystery which only the initiated can penetrate.

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* Henric Hultin (North District, Alvsborg County, Sweden) "How to achieve organisational effectiveness in health care". Paper presented to a Seminar on Ethics and Efficiency in Health Care, Turku, Finland, October 1984.

Before you reach for your pen, or telephone, or the microphone, to tell me that it is impossible (and probably even undesirable), to "keep politics out of health", let me say immediately that I agree. But many members of the medical profession do not share our views, and even some health service administrators (who should know better) bemoan "political interference" in the running of health services. So it is a slogan worth examining to see what fears lie behind it, and whether they can be assuaged constructively.

The reasons why politics intrude so prominently into health matters are because: a) health is important to people b) health care is costly c) it invariably requires public regulation d) it increasingly attracts public subsidisation e) it is often provided by institutions which are publicly owned. Against that background, how is it that anyone could imagine that it could be insulated from "politics"?

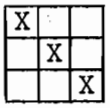
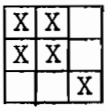
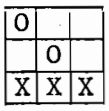
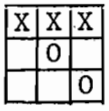
Part of the explanation lies in a commonly drawn distinction between "policy making" and "politics". No one believes that one should keep "policy making" out of health. But "politics" is different ... politics is what politicians do, and politicians are wayward, shortsighted, unscrupulous, untrustworthy, axe-grinders who seek and wield power for the sheer satisfaction of doing so, without any longterm commitment to the welfare of the sick. Doctors, on the other hand, are dependable, able to take a long view, highly principled, impeccably trustworthy, altruists whose whole lives are dedicated to the welfare of the sick. So it is clearly better to leave policymaking to doctors, and keep <u>politicians</u> out of health. In between the doctors and the politicians stand (or lie) the administrators (and accountants) who, in this caricatured scenario might be seen as stereotypical bureaucrats, trying to maintain order in a system which is constantly tending to breakdown because of the sheer complexity of the tasks it faces and the impossibility of exercising direct managerial control over the main deliverers of care. In that difficult situation the bureaucratic response is to fall back on the rule book and/or to withdraw into the formal organisational structure, and just try desperately to keep track of what is happening (even if you can't control it) and, above all else, be sure to say no whenever anyone suggests anything that is likely to make life even more difficult. It is not a pretty sight!

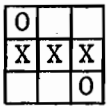
TABLE I DIFFERENCES IN CULTURE IN THE CO-OPERATING SYSTEMS OF HEALTH CARE

	Political System	Administrative System	Medical-Professional System
Education/Career	Party work Election speeches	Varying "curved" ways	Uniform, deep, one-tracked
Principals	Electorate Party	Health Authority	Patients Medical Science
Guiding principles	Justice Feasibility Social Progress	Systematic Order Principles	Quality Standards of specialty
Working organisations	Government power or Effective opposition	Hierarchy	Authority by means of knowledge
Working form	Party bargaining Voting	Collection of material Analysis Memoranda	Action Decision-making

Suppose for a moment that we could exclude the politicians from the running of the health care system, what scenarios would this leave us to consider? Continuing in the vein of parody, let us play a game of noughts and crosses, where 0 = responsibility without power, and X = power and responsibility, and the 3 x 3 grid has the following co-ordinates:

System / Actor	Adminis-trative	Financial	Medical
Adminis-trator			
Accountant			
Doctor			

The classic division of power and responsibility, that of mutually exclusive domains (Model A), can then be represented as:  . Its problems in a changing environment, are conflict, lack of co-ordination, and lack of adaptability, with enhanced interprofessional tension and mistrust as each group tries to "capture" the (absent) political role. If the administrators and accountants form a coalition, so that we have a "management versus doctors" model (B), it can be characterised thus  . It increases the likelihood that the "management" will capture the (absent) political role, whereupon the doctors will try to undermine its legitimacy by appealing directly to the electorate, playing on the latter's fears as actual or potential patients. The next model (C) is that of medical imperialism, in which the doctors infiltrate the top positions in all three systems, leaving the administrators and accountants in a purely executive capacity. This model may be characterised thus  . At the other extreme from this model are two medical nightmares. The mildest one, model D, characterised thus  , has the administrators running the whole system, and doctors doing as they are told. The more severe

version, model E, characterised as  , has the accountants running the show. These last two models might even make politicians seem an attractive prospect to doctors, but in any case the doctors are likely to manipulate the situation through direct appeals to the electorate as with model B above. So I see the desire to keep politicians out of health as a means by which each of the other actors hopes to play the politicians' role as well as their own.

An alternative to this struggle to capture the commanding heights might be to delineate areas of shared responsibility, and to offer incentives to work towards co-operative problem-solving. But that in turn requires a classification of problems to be solved. Obviously these are myriad, so I will concentrate on a handful of the strategic types of decision which characterise the system. These are:

a) What is the best treatment for a particular individual?
b) Which individuals should have priority in treatment?
c) What quantity of work is the system capable of doing if operating efficiently?
d) What facilities should be provided?
e) Who is going to pay?

Historically the medical profession has claimed competence at all of the first four levels, but especially at a) and b), which they would reckon to be "reserved" territory (i.e. others are excluded by appeal to the dictates of clinical freedom and medical ethics). Administrators are likely to see c) as primarily their territory, possibly shared with the finance people, whilst the latter would claim preeminence in d) and e), though drawing on information provided by the others. The one decision the other actors are happy to leave largely to the politicians is e).

But I believe that medical dominance of a) and b) should also be questioned, and I have elsewhere argued that "the best treatment for a particular individual" should take account of the cost-effectiveness of the available alternatives (not just their medical effectiveness), and so should the setting of priorities between patient groups.* The basis of this claim

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* See, for instance, Alan Williams, "Medical Ethics, Health Service Efficiency and Clinical Freedom" Nuffield/York Portfolios No. 2, Nuffield Provincial Hospitals Trust, London, 1984, and "Coronary Artery Bypass Grafting: An Economic Analysis", British Medical Journal, 1985.

is, in summary, as follows: doctors' specialist skills lie in their ability to diagnose and to know the effects of various courses of action which might then be adopted; and in their ability to implement, or to arrange to implement, whichever course of action the patient selects. They have no legitimate claim to impose their judgements about the relative valuations of different courses of action upon their patients. Moreover, the "various courses of action which might then be adopted" depend upon prior decisions by others about the facilities to be provided, which were made by management on certain assumptions about the social value of certain activities rather than others. If doctors then use those facilities in ways which are not consonant with those assumptions, the system's objectives will be undermined. Finally, each time a doctor "advises" (and implements) a particular course of action for one patient, some other patient is deprived of the use of those resources, so that each treatment decision has both efficiency and equity aspects (i.e. it is both about not using more resources for each patient than is necessary, and about ensuring that the "right" patients get what resources there are). The latter is a social policy decision, with high political salience, which has not been explicitly delegated to doctors, but which they took responsibility for initially because nature abhors a vacuum. Now by custom and practice, they regard it as properly within their domain.

All this leads me to the view that in a well-run health service there should be considerable interpenetration of territory by the different actors, with none of them having exclusive control over any bit of the system (not even the accountants over finance!), but with some having more influence at some levels than others, according to the kind of information and skill that is relevant at that level. But since the actors will not, and cannot, be actually present in all decisionmaking situations, then the system has to develop the education and training of each group so that they are not only capable of deploying this "external" information effectively but also motivated to do so. This means devoting considerably more attention to individuals' career development and to more flexible and imaginative organisational structures and styles of behaviour than has typically been the case hitherto in many countries.

As an example of what I have in mind as a practical example of this "power" sharing solution to the politics of health, I will briefly outline what is involved in a comprehensive clinical budgeting system, such as the

CASPE project* in the UK. This centres on the devolution of some budgetary control to "clinical teams" in hospitals (which may comprise an individual doctor and the nursing and other staff working with him, or a group of such people constituting a whole specialty), in exchange for which the clinical team discusses with the management its plans about the volume and pattern of work over the forthcoming year, and possible resource redeployments which might enable that work to be performed more efficiently. These discussions lead to a "PACT" (Planning Agreement with a Clinical Team) and if the team is able to deliver the planned "efficiency savings" it may redeploy a proportion of them (say half) in any service development it prefers, the other half accruing to the management for redeployment within the system according to their priorities. It is a system of management which places a high premium on negotiating skills and the creation of an atmosphere of information sharing and trust (initially, the confidence that PACT's will be honoured, so far as is feasible, by both sides).

It is not without its difficulties, of course, as may be gleaned from Table II which summarises the kinds of problems that can be encountered. It provides added emphasis to Hultin's conclusions about powersharing in modern health services, which he poses as a series of "provocative" questions, which I have paraphrased thus:

Doctors, are you willing and able to

- act both as doctors treating individuals and as experts offering help in planning and priority setting?
- step outside your own specialty when discussing priorities?
- consider both benefits and costs in making medical decisions?
- offer your knowledge and authority when cutting back in times of stringency?

Administrators, are you willing and able to

- be positive mediators, rather than just saying yes or no?
- generate competent cost-benefit assessments to help all participants in the decisionmaking process?

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* CASPE is an acronym for "Clinical Accountability, Service Planning and Evaluation", and a fuller account of what is involved is to be found in the writings of its leader, Iden Wickings, and his colleagues, e.g. Wickings, I., Coles, J.M., Flux, R., and Howard, L. "Review of Clinical Budgeting and Costing Experiments" British Medical Journal 1983, pp. 575/8.

Table II:. Summary Statement of Advantages and Disadvantages of Clinical Budgeting in the Management of a National Health Service

OBSERVATIONS:

No system of planning or resource allocation in a National Health Service will work well unless it:	CASPE meets these desiderata in principle in the following ways:	The problems that seem to arise in practice are:
1. Elicits the co-operation (active or passive) of most doctors.	Rewards are offered to doctors in their role of practice managers if they come up with more cost-effective ways of running their activities.	Faced with general cuts, management may renege on delivering the promised rewards. Excessive caution may so circumscribe the scope of rewards that they cease to be attractive enough.
2. Keeps strategic decision making out of the hands of any one professional group (Esp. Doctors).	Part of any savings so generated are put into the central "pool" for redeployment across the entire system in accordance with centrally determined priorities.	Management may not have sufficient drive or sense of purpose to suggest ways in which resources may be saved, or to be unable to respond constructively if proposals involve other budget holders so nothing significant emerges for redeployment.
3. Is seen to be genuinely participative at all levels by those whose activities are being planned.	At "practice" level the expectation is that nurses and other non-medicals will be involved in decision making about pacts and about how rewards are to be spent.	Consultants are still not used to sharing decision making with non-medical staff; nurses tend to be defensive even to the point of obstructiveness, if nursing levels are up for discussion
4. Generates a sense of realism at all levels about resource constraints.	By devolving budget responsibilities people "lower down" in the system are put in a similar position to that faced by the central management.	Certain contextual limitation (e.g. nationwide freezes on certain resources) may be imperfectly understood at lower levels; finance roles may be played in a negative/obstructive manner rather than a positive/constructive one.
5. Keeps itself free of artificial constraints which needlessly frustrate people's aspirations.	The traditional rules designed to maintain "control" are flexed by agreement to generate "efficiency" with the latter getting priority over the former when they conflict.	If defensive attitudes prevail because those running the system are insecure and/or inexperienced, a sense of disillusion and being taken for a ride follows.

CONCLUSIONS

1. CASPE is a system that makes much possible, but what it actually achieves depends on the strength of purpose, initiative and energy of the participants.
2. Everybody can get something valuable out of it, but only if they are willing to put something into it, viz:
   (a) Doctors get greater freedom over the deployment of practice resources in exchange for accepting responsibility for observing agreed levels of workload and resource use.
   (b) Nurses get greater say in the conduct of medical practice as it bears on nursing in exchange for sharing with doctors control over nursing levels (and also sharing in the rewards generated by resource deployment).
   (c) Administrators get more information about practice plans and an ability to influence those at a formative stage in exchange for agreeing to devolve more detailed responsibility for resource use to practice level.
   (d) Treasurers get offered savings initiated at practice level in exchange for greater flexibility in "traditional" virement restrictions.
3. It takes only one of the above groups to dig in their heels and refuse to play ball to make it no longer worthwhile for the others to continue to put in the effort required of them.

- ensure that the administrative process is itself cost-effective?

Politicians, are you willing and able to

- engage in direct open dialogue both with administrators and doctors?
- devote time to learn about the problems of the health care field in depth?
- get more time to do this by delegating decisions wherever possible?
- influence and control developments at a much earlier stage by getting involved long before the time when decisions are needed?
- ensure that pressure group demands are always considered in the broadest possible context?
- accept public responsibility for any restrictions that have to be imposed for reasons of economic stringency?

"Each separate question is certainly difficult and inconvenient to every group of actors involved. Even so, a guide to being able to answer yes, and act accordingly, is perhaps to consider the alternative ..."

To conclude I must return to an issue that I mentioned in passing earlier, namely, the fact that the decisions we are considering involve both efficiency and equity considerations. My general view is that matters of equity are essentially for the political system to resolve, whereas matters of efficiency could be left to the other actors in the system to sort out, under the pressure of (politically determined) resource constraints. Prima facie this suggests a clear division of labour, which, unfortunately, cannot easily be implemented because politicians cannot in practice choose which actual patients shall be treated and which not. They can only lay down broad guidelines which they hope will be put into effect by the doctors, etc. But doctors then see themselves in an ethical dilemma, because they are strongly indoctrinated with the view that their duty lies in doing the best they can for the patient in front of them no matter what the cost (i.e. no matter what sacrifices other patients thereby have to bear). But distributive justice dictates that there must be some balancing of the good and bad effects on different individuals in accordance with the ethical position adopted by the community which is being served, as articulated by its political representatives. Thus if we have doctors as the advocates

of the ethic of duty, management as the advocates of efficiency, and politicians as the advocates of distributive justice, we are back at the beginning once more with a new variant of Model A!

So, if my agenda for a more co-operative style of health service operation is not already daunting enough, we can add to it the need to indoctrinate doctors with the ethic of distributive justice, to set alongside the ethic of duty, and to help them come to some socially acceptable resolution of the conflict between them! Thus far from keeping politics out of health, if politics means "equity" considerations, my preferred strategy would be to have politics permeate the whole system so thoroughly that we don't need to leave it all to the politicians. Indeed we might have politics permeating health, yet not a politician in sight!