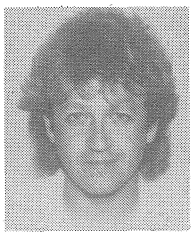
Case Conference

The shadows lengthen at close of an autumn day at the Western Regional Health Authority of Lesser Utopia. The Director of Contracts reads over again the two conflicting proposals for the purchase of surgical services to the Eastern Province of the region. The first proposal continues the existing pattern of provision of surgical services through a combination of the base hospital at Glengarry, the only city in the province, and a smaller hospital at Eweville. Eweville is the service centre for a large rural district of some 25,000 persons. Residents of Eweville district have about half of their surgical procedures at their local hospital by two resident surgeons, and travel to the base hospital at Glengarry two hours away for surgery not available locally. This proposal has a number of attractions; its familiarity and support by the local community, well established working relationships between local GPs and surgeons, and the minimal disruption to existing service providers. There are problems however: the Royal College of Surgeons of Utopia has advised that maintenance of professional standards may be difficult for surgeons practising in small hospitals such as Eweville. The Health Information Manager has advised that surgical rates for residents of Eweville district are 50% higher than the national average, raising the possibility of overservicing (there are no waiting lists at Eweville). Thirdly the costs of purchasing surgery at two hospitals is substantially greater than if all surgery performed at Glengarry.

The second proposal is to contract with Glengarry hospital for all the surgical workload of the province. This is supported by the surgical staff at Glengarry, the Royal College, and the Director of Finance. This proposal too has problems: in particular poorer access to and higher personal costs associated with surgery for residents of Eweville district. Emergency services at Eweville would also be adversely affected. Last week a crowd of several thousand people had linked arms around the hospital in a graphic demonstration of local support. Yesterday's Ministerial memo again noted the importance of "seamless transition" to the new health structures during this financial year (which is also election year in Lesser Utopia).

The Director of Contracts fidgets somewhat restlessly with the briefing papers. **What recommendation should be made to the Health Authority Board? What are the ethical issues involved? What other factors should be drawn to the Board's attention ?**

COMMENTARY 1



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What cost? What sacrifice?

The Director's restlessness is understandable. She faces a situation where she is bound to upset someone whatever she does. But what is even worse, she is not at all sure what the central problem is. Is it primarily a political issue? Does it boil down to money? Is it basically a question of ethics? Before she can work out any solution she must first determine the essential shape of the dilemma.

Her most superficial choice is to characterise the problem as simply a matter of politics. If she sees it like this she must weigh up the relative power of the opposed groups, and then take the safest bet. She may conclude that it will be least damaging to concur with the majority of 'professional experts', she may opt to show the 'caring face' of the WRHA by responding to 'local needs' or she may try to fudge it until after the election.

Alternatively she could try to capture the puzzle in financial terms (in keeping with the spirit of the age). At least she will have an argument with this option. Of course this is not a prerequisite for policy-making (as the recent, and remarkably similar history of the New Zealand and British health services shows) but even in 1993 a coherent line of thought can still sometimes impress. The Director's thesis might go like this: health care eats up a major and increasing proportion of New Zealand's resources, therefore it is in the 'national interest' that savings are made wherever possible. Fortunately an opportunity to save money has arisen. It will without doubt be cheaper to 'rationalise' surgical services and to contract solely with Glengarry, therefore this is what must be done.

This proposal has an additional attraction: it offers the sanctuary of the crowd. But its drawback secretly feared by all followers of fashion - is that much greater problems will begin if the Director is challenged to explain herself. What is the 'national interest'? What will the money be saved for? Why is 'rationalisation' so compelling?

As a third choice she might, if she is really canny, cast the problem as an 'ethical issue' and throw it open to public debate. This way the Eweville surgeons will be able to explain their duty to care for the local community, while the 'rationalists' will have a chance to emphasise the wider utilitarian benefits afforded by a single surgical unit. The Director might argue that since ethics is ultimately a matter of individual conscience, those most closely involved must reach consensus. If they do not then she will abide by the clear majority opinion.

The hardest option

The Director's fourth (and hardest) choice is to recognise her challenge for what, at the bottom, it really is. That is, she might deal with the dilemma philosophically. In order to do this she must go beyond politics, money and even contemporary ethics, and attempt to clarify the conceptual issues. This greatly expands her problem, and she has no obvious incentive to do this. Nevertheless, if she wants to understand the dilemma rather than merely get it out of the way she must take a philosophical view.

She might, for instance, reflect upon the basic purpose of health care activity. If she reaches the conclusion that health work is simply and only to do with the efficient prevention and elimination of disease and injury, then she may lean towards the Glengarry option. However, if she feels that 'the basic drive against disease' is sufficient justification for the centralisation of services she cannot simply ignore the wider implications. Unless she stops

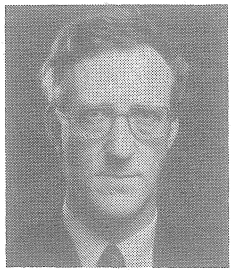
her deliberation arbitrarily she must consider how else the WRHA's resources could be redirected to achieve the goal of 'health'. She might then find herself compelled to recommend to the Minister that new laws be implemented to ban the sale of alcohol, or to oblige all citizens to exercise regularly, or to ban the use of private transport. These measures too would most probably be very effective in the prevention of disease and injury.

If this strand of philosophical reflection becomes too fraught the Director might instead decide to think about the nature of cost. It is often assumed that the 'cost' of something means its price in money, but this is not the way economic theorists think of it. For the economist a 'cost' is simply a sacrifice of some kind. So the cost of not learning to drive is not only calculated in the financial price of bus tickets and taxi fares, but also in the loss or sacrifice of the freedom which a driving licence can bring.

It may just be that if the Director seriously pursues this idea she will find the 'financial case' too simplistic. All other factors being equal it is undeniable that money will be saved through the Glengarry option (even if it means a little more expense in travelling and accommodation for the Eweville locals). It is much less clear that the money will be reinvested in the health care system, but even assuming that it will be it still does not follow that the reduction in financial expenditure is the primary and overriding benefit. If 'cost' is interpreted according to the logic of health economics, if cost is seen as the sacrifice of potential personal autonomy (or people's control over their circumstances), and if it is true that the inhabitants of the Eweville district will feel undermined, disempowered and even a little less hopeful about their lives, this cost may far outweigh the more obvious financial savings.

Money is, in any case, nothing more than a means to greater ends. If the point of making savings is to reinvest the money in other projects for the benefit of the New Zealand people then the ultimate concern is not 'saving money' for its own sake, but saving money in order to do better things. Thus the question becomes not 'how can we cut financial costs with the least fuss and upset' but 'how can we use all our resources to ensure the best lives for all our people'. And once this question is asked the debate must move beyond the level of the business man's boardroom, to the thorough and earnest consideration of the question: which human goals are most desirable? If one of the answers is that feeling powerful and hopeful are vital human ends, then not to aspire to these in order to save money is a quite bizarre choice of sacrifice. It is a 'false economy' in the most profound sense.

COMMENTARY 2



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First of all it must be clearly understood that as a member of a purchasing board my aim would be to do good in the utilitarian sense in contrast with the providers who must now try to run at a profit. This will require identification of the business they are in and inevitably induce them to give up non profitable activities.

It would have been helpful if the CHE status of the hospitals was given, the size of the city of Glengarry and the range and degree of specialisation of its hospital services specified.

The clear definitions of context, issues and data required by ethical analysis are helpful in resolving the type of dilemma presented in this scenario. Whilst a number of ethical principles are involved (paternalism, waste, beneficence, respect for others, truth telling and fairness) the key issue is, I believe, one of accountability. Both purchasers and providers are accountable either directly or indirectly, to the communities of Eweville and Glengarry. In turn each community must accept responsibility for working with the Health Authority to achieve the best for themselves without prejudicing delivery of appropriate levels of care to the other. Health professionals whose accountability has until recently been ill-defined and largely related to medicolegal transgressions, are now accepting greater accountability for the ways in which they work and use resources.

Paternalism and waste should be minimised. In this instance, the attitudes of the surgical staff at Glengarry, the Royal College of Surgeons and the Director of Finance, may be perceived as paternalistic or expressions of professional self interest rather than addressing the needs of Eweville. As far as waste is concerned the Health Authority must examine closely, and if necessary reduce the apparent over-servicing of surgical services in Eweville through the design of its contracts.

Respect for autonomy of both individuals and the communities to which they belong includes recognition of their ability to make informed decisions and choices. This must be clearly acknowledged through the steps taken by the Health Authority to consult and listen to representatives of the community including its health care providers. The Eweville community will inevitably have to accept trade offs such as less specialised levels of care, if they are to achieve what similar communities generally seem to want most, namely easy access to treatment for acute life threatening conditions and provision for longer stay and convalescent care within the local hospital. On the basis of experience elsewhere it is unlikely there would be resistance to travelling to Glengarry for the more sophisticated elective procedures.

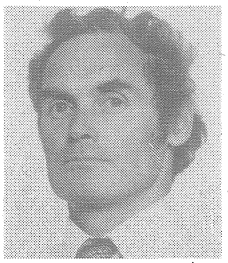
Truth telling or honesty includes close attention to semantics, particularly varied interpretations of words relating to service provision and costs. The word "cost" itself has different and wider meanings for patients, their families and health professionals than for accountants. It is dishonest to imply that there are only two options in this scenario, particularly when the possibility of working differently does not seem to have been considered. The early transfer of post-operative patients back to Eweville and the moving some non specialist elective surgery from Glengarry to enable it to undertake more specialist work referred from other centres are examples. The needs of the acutely ill must be clearly distinguished from those of patients requiring elective surgery and the full repercussions of any withdrawal or reduction of acute surgery on all other clinical and non-clinical services identified. The close and complex inter-relationships between different specialities are not always sufficiently appreciated by health planners and management.

Recommendations to the Health Authority Board

Procedures should be established to increase dialogue between the Health Authority and both communities, particularly Eweville. These should involve community representatives, general practitioners and hospital staff, particularly clinicians, in order to identify the community's needs and priorities and also acceptable trade offs to be made explicit through the balance of cost and quality in service contracts. The contracts drawn up with both hospitals should be conducive to sustaining acute clinical services at Eweville. They must encourage a recognition by both hospitals of the need to work closely together to make best overall use of resources and to develop a more business-like and customer orientated approach. There will be a number of matters of mutual concern such as the maintenance of professional standards of Eweville surgeons which are their responsibility rather than the purchasing authority's responsibility.

The Health Authority must establish procedures which ensure the accountability of all involved at Eweville and Glengarry in both the delivery and use of resources. Its decisions and in particular the means by which they are reached, must be made explicit, especially where they relate to resource restriction.

COMMENTARY 3



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The Director of Contracts has a dilemma between cost efficiency, maintenance of standards, the problem of alleged "overservicing" on one hand and the conflict engendered in a small community by the threatened withdrawal of a local and well established service:

a) *Cost efficiency*

It is stated that the overall costs of performing surgery exclusively at Glengarry are less than the two established services. This does not take into account the personal cost to patients and relatives with accommodation, travel, subsistence and isolation from friends and relatives. It also does not take into account that transferring the patients from Eweville, where there is a negligible waiting list, to Glengarry where there is a considerable waiting list, especially for minor procedures, will reduce the costings as patients do not become a cost factor until they become inpatients. Also not accounted for is the ability of Glengarry to service the increased load if the system is to be efficient, due to already existing financial constraints at Glengarry, theatre availability, bed availability and other constraints imposed by the financial difficulties of Lesser Utopia. The expense of maintaining a theatre and staff in Eweville for itinerant day surgeons would achieve the worst of both worlds.

b) *Maintenance of standards*

Tertiary referrals can be omitted from the discussion as Glengarry is funded for such cases. The argument revolves around the Eweville surgeons having adequate numbers of non-ordinary cases e.g. complex bowel resections, to maintain standards of the higher order. As referral of complex cases and trauma to Glengarry coupled with efficient transport is instituted the argument of distance becomes irrelevant. (After all many Lesser Utopians are prepared to travel large distances to see their favourite national sports teams play without a thought as to the inconvenience.) Health problems however pose a different emotional approach. The Royal College of Utopia would be unhappy to recommend its Fellows to work in a unit performing only "minor" surgery.

c) *"Overservicing"* is a term frequently used by administrators to conceal the inefficiencies of over-large waiting lists, a problem seen by clinicians as a reality in patient suffering and inconvenience, including death on some waiting lists. That is, the problem of the long waiting list is one of under provision of service rather than overservicing in the peripheral hospital. Some might even argue that Eweville is providing a highly efficient service to its Community within the limited resources available. It may also be argued that increasing the waiting lists at Glengarry merely conceals the problem - administratively tidy, but patient inefficient.

The ultimate limiting factor in all the argument is the availability of funds to provide a speedy, efficient, safe service to all needful members of all communities in the Western Regional Health Authority's care. This, as directed by the "Seamless transition" concept, argues that the surgical services at Eweville should be abandoned and all surgery performed at Glengarry. What is not clear is the transfer of funds already in place to provide services from Eweville to Glengarry, the reorganisation of Glengarry operating and bed schedules to accommodate the load, provision for social services to alleviate the costs to "needy" persons, the availability of efficient and rapid transport systems to bring acute and emergency patients to Glengarry and the appropriate and fiscally neutral transfer of staff both medical and nursing to strengthen the establishment at Glengarry.

d) *Community dismay*

Although this is a real problem for Eweville, unless the community can raise funding to maintain the existing surgical services, the present financial constraints argue against maintaining services in Eweville. The community's display of support for the status quo is however not an argument that administrators fiscally responsible to the Health Department can tolerate in the present economic climate.

The recommendations the Director of Contracts should make are therefore:

1 All surgical services should be provided by Glengarry.
2 Appropriate compensatory mechanisms should be in place to fund adequately; a) the increased load at Glengarry, and b) the financial inconvenience of the "needy" of Eweville.
3 Efficient transport should be available to provide rapid evacuation of "urgent" patients.

Ethical considerations would include:

a) patient safety in a minimal service
b) adequate quality assurance programmes and standards both for Glengarry and Eweville in the altered circumstances. c) care of relatives in the inconvenience of "away from home" surgery. d) Appropriate care of staff who may become redundant in the new regime, if unable to transfer to Glengarry.

The Director of Contracts can stop fidgeting restlessly and seize the nettle of quality service within a restricted budget.