Value for Money in Health Services

by BRIAN ABEL-SMITH*

The Robert M. Ball Lecture Series, established in 1973 as a tribute to the former Commissioner of Social Security, was designed to present the ideas of distinguished leaders in the field of social policy to the staff of the Social Security Administration and their guests. The first of the lectures, presented essentially in full below, was given by one of Britain's foremost authorities on social welfare and health services.

Professor Abel-Smith discusses current attitudes toward the provision of health services, presents his views on quality of health care, and looks at different approaches to the problems of the health delivery system—regulation, structured planning, and improvements relating to those who operate the system.

THERE ARE NOW so many innovative experiments, so many varying solutions to the problem of rising costs, and so many different plans for health insurance that it is not easy to discuss in some 50 minutes—in a country not your own—a question of such bewildering complexity as how to get value for money in health services. What is quality? Whose money? What ultimately are health services?

I can only discuss the subject by greatly simplifying the issues. Moreover, there is one great simplification I must make. I must ignore your political realities, simply because I am in no position to judge what they are or will be.

ATTITUDES TOWARD PROVISION OF HEALTH SERVICES

Some 20 years ago, on an early visit to Washington, it seemed to me that compulsory health insurance was not on the map, Government planning of hospitals seemed little more than a dream, and Government price controls unthinkable. It was before your language or at least your alphabet had been embellished by such concepts as PPBS or PSRO or HMO. Health insurance was voluntary in the curious sense in which the term is used over here, though vast numbers of individuals were forced to buy it or have it bought for them as a consequence of the jobs they had taken. Health insurance was and still often is heavily restricted by copayment, coinsurance, and deductibles—by what we in England simply call charges.

There is now more of a demand that people should have health insurance though not necessarily health care as a right—a distinction to which I attach great importance. There is somewhat less concern about what I used to see curiously described as the moral hazard of the insured. (Is it immoral to want more health services?) How many of us are such chronic hypochondriacs that we are likely to camp out on our physician's doorstep, take our vacations in hospitals, or beg for prescriptions we can fill? Or are we worried that people may make hats out of gauze and suture? Is this immorality or a special form of sickness?

Now more attention is paid to the incentives and moral hazards facing the unregulated provider. It is increasingly accepted that it is the physician who authorizes the use of most of a nation's resources. While it is the patient who presents himself to the physician, it is the physician who terminates the interview, suggests a further consultation, writes the prescription, orders the diagnostic tests, arranges the hospital admission, recommends the surgery, and authorizes the hospital discharge. In an unregulated system there is a moral conflict for the physician between what is best for him and what is best for his patient.

There is less faith now in the combination of consumer demand and competitive free enterprise as mechanisms for controlling cost and promoting quality. Perhaps it is Medicare that brought home to the more straightlaced economists that the market for health services is no ordinary market.

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Does the consumer make a free choice between purchasing medical care or purchasing a new automobile when he is told the serious consequences of not having surgery or lies unconscious at the emergency-room door? As Professor Berki put it, "Medical care is not a good: it is a least bad."[1]

Increasingly it is accepted that, while the ordinary consumer can judge standards of amenity and levels of care, he can seldom judge the quality of medical intervention either before or after he has received it. Few of us challenge the recommendations made by our physician when they are made, though over here they are not infrequently challenged afterwards in the courts. We place ourselves in his hands to provide us with what he thinks we need and to make purchases for us in the health market. All over the world, the physician is not only a provider but a purchasing agent or rationer of resources on a vast scale, whether he recognizes this role or not.

Is the physician trained and motivated to get value for money in the use of the resources he authorizes for his patients? If not, does the market for health services have other forces working within it and do they lead to higher quality or to lower quality, to waste or economy? Do the invisible forces of the market ensure that what the consumer hopes to get is available where he wants to get it? When market forces fail to promote economy, quality, and equitable distribution, how have the governments of other countries — particularly European countries — intervened to regulate the health market to correct this situation and with what effect?

NATURE OF FREE HEALTH MARKET

There are five fundamental propositions about a free health market that I believe to be true. I acknowledge that not all of them can be supported by scientifically valid proof. Indeed, all sorts of hangups stop us from introducing the carefully designed experiments that could give us this proof.

My first proposition is far from original, nor is it accepted by all observers: Within limits the supply of hospital beds generates the demand for them. Milton Roemer is credited with formulating this proposition,[2] but in more and more countries it has come independently to be accepted. When the money barrier is removed, the need for hospital beds is not the same as the demand for hospital beds. It is, of course, very difficult to establish the need for hospital beds, and I will return to this subject later.

My second proposition is that unregulated competition in a free health care market can lead to a loss of quality in a number of different respects: it can lead to unnecessary surgery; it can lead to excessive prescribing of effective drugs, of ineffective drugs, and of dangerous drugs; it can lead to suboptimal skill and performance. An excess of specialists means a lower average experience in specialist work. A part-time heart surgeon who only occasionally uses this particular skill will function less well than a heart surgeon who regularly uses this skill. The operating team that is only occasionally called together will function less well than the team that works together regularly. The more cases a specialist sees in his specialty the more skill he will acquire in distinguishing them and treating them accordingly.

My third proposition is that the free forces of the market under an unregulated fee-for-service payment system do not secure an even geographical distribution of physicians. Again within limits, physicians can enter communities already generously supplied with physicians and make a living —particularly if they come with specialist qualifications. Doctors can make work for themselves when they are plentiful. Economic forces alone are not sufficient to attract doctors to work in areas where they are not otherwise inclined to want to work.

Fourth, the physician is trained to buy the best rather than find the best buy. After training he is exposed to conflicts between his conscience and his pocket and conflicts between the interests of his paymaster and those of competing commercial interests. His doormat is piled high with drug firm literature, and his doorstep is shaded by drug house detail men. Over his shoulder looms the risk of malpractice litigation. His hospital, rather than any other, is his pre-

[1] Sylvester E. Berki, *Hospital Economics*, Lexington Books, 1972, page 131.

[2] Milton I. Roemer, "Bed Supply and Hospital Utilization: A Natural Experiment," *Hospitals* (American Hospital Association), Vol. 35, No. 21, 1961.

ferred workshop. Nearly all his decisions are of financial consequence to him as well as to his patient or the third party paying the patient's bill.

My fifth proposition is that where the physician is not cost-conscious and the patient acts on his advice there is no pressure on those from whom he purchases to be cost-conscious either. The drug market is carved up by patients and branding: competition is by product and not by price. Unless they are regulated, nonprofit hospitals enjoy what almost amounts to the arbitrary taxing powers of medieval princes. They use these powers to finance the twentieth-century palaces that dominate both cities and suburbs—palaces with almost the same proportion of underoccupied bedrooms and a much higher proportion of underoccupied powder rooms.

HEALTH CARE EXPENDITURES AND GROSS NATIONAL PRODUCT

National income accounting was not employed by medieval monarchs so we do not know what proportion of GNP was used in constructing and running their palaces. We do know what countries are spending on their health services though each country defines them in a slightly different way.

Some years ago I analyzed international trends in health expenditure in the 1950's and concluded that most developed countries seemed to be transferring an additional 1–2 percent of GNP to health services in a 10-year period.[3] This trend has continued in the sixties as Joseph Simanis[4] and others have shown. By the end of the sixties the United States, Canada, and Sweden were all spending 7 percent or more of their resources on health services. If present trends continue, several countries will be spending a tenth of their resources on health services before the end of this century. Nor is this only in prospect for Sweden or North America. Projections for Australia indicate that medical expenditures will reach 12 percent of GNP in 25 years' time.[5] Projections for France show medical expenditure as 11–13 percent of GNP by 1985.[6]

EFFECTIVENESS OF HEALTH CARE EXPENDITURES

What are we likely to get for all this money? What indeed are we getting for what is being spent now? Is this money spent to provide maximum health care out of the health dollar? Here we have to admit the ambivalence of our societies. We worship speedy transport at the price of vast carnage and maiming on our roads. We tolerate poverty and slums and all the health risks that they generate. We tolerate industries that pollute land, sea, and air and maim or disease their workers. We encourage sedentary work, stress, and striving as if they were proved to be the inevitable price of economic progress. We put little emphasis on safety in the construction of our automobiles or the design of our industrial processes. We do little to promote or facilitate vigorous exercise to control our coronaries. We are reluctant to redistribute income or ensure adequate standards of housing. We do not ban cigarette smoking to protect our hearts and lungs. We do not provide free prophylactics to protect the promiscuous from venereal disease. We look to the health services to cure us whatever we do to ourselves.

While much more could be done at little cost to prevent ill health in ways known to be effective, much is done in the cause of curing ill health that is of questionable effectiveness, known to be ineffective, or known to be unnecessary and dangerous. For some time, many countries have been trying to remove from the market that vast range of pharmaceutical products which are known to be ineffective or for which manufacturers' claims of effectiveness are not substantiated. In addition, many effective drugs are overused. I am not just referring here to the staggering use of sleeping pills, tranquilizers, and antidepressants but to such classic problems as the overuse of chloromycetin. I am referring also to excessive surgery—and all surgery has risks attached to it. It is a matter of concern when without good cause so many people lose their appendixes, their wombs, or their tonsils.

[3] Brian Abel-Smith, *An International Study of Health Expenditure*, World Health Organization, 1957, page 92.

[4] Joseph G. Simanis, "Medical Care Expenditures," *Social Security Bulletin*, March 1973.

[5] Ministry for Social Security, *The Australian Health Insurance Program*, Canberra, 1973, page 2.

[6] P. Comillot and P. Bonamour, "France," in *Health Services Prospects: An International Survey*, Nuffield Provincial Hospitals Trust, 1973, page 75.

Many expensive innovations in medical care come to be generally used before there is robust evidence that they really work. And once they are in general use it is regarded as unethical to evaluate them. It is, moreover, risky for the physician in terms of possible litigation. In making such bold statements about medicine, I am relying on the evidence accumulated by Dr. Archie Cochrane, President of our Faculty of Community Medicine.[7] His book should be compulsory reading for all those sociologists, economists, operations researchers, systems analysts, and futurologists who are now applying their skills to the health industry. Too often it is assumed that hospitals and physicians have not only uniform outputs but outputs of the same quality and outputs that are wholly beneficial. Such assumptions open the door to sophisticated yet irrelevant regression analysis but not to enlightenment or wise policy formation.

Dr. Cochrane quotes the results of a random-controlled trial in Bristol which "do not suggest that there is any medical gain in admission to hospital compared with treatment at home," for ischemic heart disease. He also quotes trials showing that insulin treatment is no better than diet alone in treating mature diabetics, that iron does not cure the classical symptoms of anemia at certain hemoglobin levels, and that ergotamine tartrate does not help newly diagnosed cases of migraine. As no random controlled trials have ever been carried out to evaluate them, he casts doubt on the value of surgery for carcinoma of the lung, cytological screening tests for the prevention of cervical carcinoma, and dietetic therapy for phenylketonuria.

Technical Innovations and Developments

Ultimately, we are concerned with health rather than health insurance. Problems of quality are not solved by removing the money barrier and pumping in resources to ensure that what the individual physician demands is supplied. Nor indeed are the problems of distributions solved. Ultimately, society must be concerned about the quality of medical practice, and this is not just a question of the money incentives on the doctor or even of commercial interests attempting to distort the physician's judgment. We know that the physician can quickly become out of date after he has left medical school. What is even more challenging is that leading physicians can come to accept as advances expensive technical innovations which no individual physician can evaluate from day-to-day practice.

What mechanisms do we need to prevent whole societies from spending vast sums of money on innovations of unproved value? How can we reconcile the need for such mechanisms with such cherished notions as clinical freedom and the free practice of medicine?

At the very least, we need to ensure that new and expensive developments are not widely adopted until proper control trials have been conducted to establish their usefulness. Your society and many other societies accept this in principle in the case of new drug products. You require evidence that a preparation is effective and of acceptable safety before it can be marketed. Why is not similar proof required for such innovations as coronary care units?

I have already mentioned the difficulty you are having in getting old, ineffective drug products removed from the market. But marketing control does not deal with the wider and no less dangerous problem of the inappropriate use of drugs. What would puzzle an observer from another planet is our attitude toward the education of the physician. After his initial education we allow him to be exposed to a course of education by competing commercial interests that costs much more over the professional's life in practice than his original education. Surely advertising by commercial interests should be wholly replaced by noncommercial continuing education. Such education would be wider, much more cost effective, and fundamental to the promotion of quality of care in an era of rapid technological change.

Drug Prices

Action is surely needed to control the prices paid for drugs in view of the vast profits that emerge from patents, branding, and other market

[7] A. L. Cochrane, *Effectiveness and Efficiency* (Rock Carling Fellowship, 1971), Nuffield Provincial Hospitals Trust, 1972.

imperfections. Of course we want to encourage research and of course successful innovators deserve rewards. But should the innovators themselves decide within wide limits the scale of their rewards? The scale of the problem can be reduced by the wider use of generics, by the restriction of proprietary rights to brand, by rights for pharmacists to substitute, and by reduction in patent life. But should prices as a whole be subject to regulation—not only those charged by suppliers but those charged by chemists? Many European countries—not least Britain—have had considerable success in this field.

In Britain, prices for National Health Service drugs are centrally negotiated against a background of legislative sanctions and the markups of pharmacies are also centrally negotiated. As a result, pharmaceuticals cost less in Britain than in virtually all other developed Western nations. In Sweden and Denmark, import controls are used to control both the effectiveness and the price of drugs. Medical committees decide what can be allowed in taking account both of effectiveness and price.

At first sight it seems that what society wants is the provision of all those curative actions and preventive actions that are effective at the lowest costs at which they can be provided. This is to take a mechanistic and narrow view of medicine. We also need placebos that are no more expensive than is necessary to achieve their purpose. Last but not least, we need care both when we are being treated and when cure is not in prospect. It is a paradox of so many medical systems that so much is spent on ineffective cure and so little to promote standards of care. Indeed, in fee-for-service health insurance, care is underrewarded.

PATHS TO INTERVENTION

I have explained why I believe it to be necessary for societies at least to regulate if not to plan or even control the provision of their health services. There are, it seems to me, three paths to intervention. The first is the regulation of services that are delivered. The second is the planning of the system of delivery. The third is action to change the behavior of those who control the system. All three approaches can be applied simultaneously, or different approaches can be applied to different parts of the system.

Regulation

Regulation is the road down which you seem to be moving at an accelerating pace. Indeed, outside observers like myself cannot keep pace with the number of different regulating agencies. Of course, I have long been familiar with what I call the persuasive type of regulation which underlay the Hill-Burton Act, accreditation, and peer review. Now I must try to understand the potentially more restrictive if not punitive regulation of the payment systems under Medicare and Medicaid. I must understand your cost control regulations, your certificates of need, and the potentiality of PSRO (Professional Standards and Review Organizations).

Post-event regulation.—The general drift of policy is towards the control of the construction of facilities and the evaluation of services after they have been delivered. Post-event controls are, of course, widely used in many European systems of health insurance. But in general they are only used to police extremes by examining patterns of resource use that are far above average—excessive consultations, prescribing, diagnostic tests, and medical acts. Physicians or administrators may pick out the doctors who seem to generate high costs, but any disciplinary action is normally taken by local committees of doctors who examine very carefully the circumstances of the patients.

Perhaps the most ingenious solution is that of Germany where doctors are paid from a local fund established by the income of the health insurance system. If services increase then every doctor may only be paid 90 percent or 80 percent of his fees. This places the responsibility on the local medical association to deal with those of their colleagues who are making excessive demands on the fund. Normally, the purpose of some systems of regulation is not so much to catch the offender but to discourage others from committing such offenses.

(An alternative system of regulation, used to some extent in Europe, is to require prior approval before some procedures are undertaken. But this also requires duplication of the diagnostic

work and anyway can only be used for nonurgent needs for medical care such as dentistry and "cold" surgery.)

In the United States, however, you seem to be going further towards a more comprehensive effort to keep costs down and control budgets and prices. If such systems are used to do more than punish the worst offenders, they could themselves become very costly. While computers can be programmed to pick up cases that need examination—and this is not inexpensive—the process of examination virtually involves a dummy run of the diagnosis and treatment, a still greater duplication of professional work.

Moreover, world experience has shown, as the United States experience is also beginning to show, the paradox underlying attempts to preserve the free and independent practice of medicine. At first sight, fee-for-service payment enables private free-market medicine to be readily combined with health insurance. In practice, it is not long before interference with medical practice becomes much greater than occurs or needs to occur when physicians are salaried employees in government service. Physicians are made answerable for each of their acts. Because there are incentives for abuse, restrictive and punitive safeguards are established to prevent abuse from occurring. Sometimes the punishment falls on the physician, but sometimes it falls on the patient.

The most important risks attached to this type of evaluation of medical acts is that the values hidden beneath the system of evaluation may be not just inappropriate but positively harmful. Carried to their logical conclusion they imply a false standardization of patients' needs and of patients' social situations. For example, at first sight it would seem possible to detect statistically unnecessary or inappropriate use of hospital beds. But what is appropriate for a particular patient depends on the alternatives available for that patient. Post-event regulation can only operate on what is available to be used. It cannot alter supply. It cannot create alternatives to hospital care that do not exist. The regulation system may induce the physician to chop 2 days off Mrs. Jones' stay in the hospital. What value is this if Mrs. Jones cannot obtain proper care after her discharge and has to be readmitted? What is wrong is to apply to human beings systems of cost control appropriate for securing the most economical production of battery hens.

Certificate-of-need regulation.—Quite separate from post-event regulation, you are gradually evolving towards what is, in my view, often incorrectly called certificate-of-need regulation. Often it is not a certificate-of-need but a certificate-of-demand. This depends on whether the aim is to restrict the number of beds to those that seem to be demanded or to those that are calculated to be needed according to some criterion. In the long run, this could have more impact on the system. It is not enough, however, to be able to refuse permission without having any authority to initiate action either to build more beds when they are needed or to develop alternative patterns of care that would make more beds unnecessary.

What are in effect certificate-of-need regulations are now widely used in Europe—not only in Britain and Scandinavia, but in continental Europe. There has been a burst of legislation in the last decade that has attracted little attention over here: The French law of December 31, 1970; the Dutch law of March 25, 1971; the Belgian law of December 23, 1963; and the German law of June 29, 1972. The general tendency in Europe now is to look more at the number of beds needed rather than at the number currently demanded. The switch from demand to need implies mechanisms for providing alternative ways of meeting demands.

Restriction by area.—One use of regulation that would at present be unacceptable in the United States but is found in several European countries is restriction on the number of doctors who can practice in a particular area. In Britain, Finland, and Sweden there is tight control of the number of posts in particular specialties in hospitals in each area and this controls the vast majority of specialist work. Medical establishments are laid down centrally for each hospital—not only in total but in each specialty. Britain goes further and designates certain areas as "overdoctored" for general practice. Only in special circumstances can a doctor enter general practice under the national health service in an overdoctored area. But, again, supply restrictions can only be operated in the context of the way medicine is practiced. The supply of doctors required for a community depends on the number and qualifica-

tions of staff working with them and thus what can be safely delegated to them.

Planned and Structured System

It is because of all these limitations of action to regulate events or to control the quantity of supply that some countries are going further and attempting to control the character of the supply —in other words, to change the system. Attempts are being made in more and more countries in Europe to push both hospitals and primary care into a planned and structured system, as well as to change incentives for those in the health care system.

Structuring of hospital system.—There have been two main reasons for planning a structured hospital system. First has been the desire to eliminate the provision of the rarer specialties in small, costly, and inefficient units within most general hospitals by concentrating them in designated regional hospitals. The second has been the desire to prevent the use of the general acute hospital with its expensive facilities by those who do not need these facilities and can be treated in smaller community hospitals nearer their homes. The purpose of all this planning is not so much to save money but to promote quality of care.

In Britain the desire to plan hospitals on a regional basis was one of the reasons for taking hospitals away from local government and nonprofit bodies when the National Health Service was established in 1948. The location of the rarer specialties is now planned on a regional basis in Britain by ad hoc public authorities, and we are currently rethinking the precise role of small community hospitals within our hospital structure. In Sweden, regional hospitals are currently being developed that will alone provide the rarer specialties. The location of these hospitals has been carefully chosen to minimize travel time and travel costs for patients.

If it should be thought that this type of planning would be tolerable only in countries with socialist governments, I should add that regional planning is also being imposed in both Germany and France. In Germany, the Central Government requires the counties (*lander*) to collaborate with the hospital associations and health insurance agencies to produce regional plans. Public money for depreciation or construction is denied to any hospital project that does not fit in with the regional plan.

France is now divided into 21 regions for hospital planning purposes. A commission for each region is appointed by the Central Government to plan hospital construction needs. No new hospital—public or private—can be built without the authorization of the Ministry. In each region, one or two regional teaching hospitals are the sole providers of the rarer specialties. Under the Law of 1970, public and private hospitals are being formed into districts that are intended to have a common management eventually. This law is designed to do for French hospitals what was done for British hospitals by the Act establishing the National Health Service.

Structural change in Europe has not been confined to the hospitals, however. In Britain, Finland, and Sweden there has been a rapid development of health centers in which doctors provide a full range of curative and preventive services and work with related staff in premises owned by public authorities. In Finland, the system is most developed, and general practitioners who used to be paid under fee-for-service are now paid by salary though they are allowed to see private patients after they have done their designated hours for health insurance. In Sweden, the vast majority of doctors in clinic practice are now salaried. In Britain, more than half the remuneration of general practitioners comes in the form of payments that are akin to salaries—initial practice allowances, seniority payments, and other payments that vary neither with the number of services nor with the number of patients for which the doctor accepts responsibility. Moreover, home nurses and public health nurses increasingly work from doctors' premises—both those that are owned by the practitioner and those that are not—and each practitioner can in addition be reimbursed for two-thirds of the salary of two ancillary workers.

The provincial government of Manitoba (Canada) is planning "a controlled and substantial experiment in community health centers." Many of you may also have read the Hastings Report on health centers for Canada as a whole. Simi-

larly, Australia is making experiments with community health centers. Thus in more and more countries it has been accepted that the use of hospitals depends upon the extent and coordination of provisions outside hospital. This idea has also been accepted in the United States in the context of proposals for health maintenance organizations (HMO's). But what is critical is that these countries are trying to plan ways of providing quality community care services, not just to save hospital costs.

In many countries of Europe, thinking goes still wider. It is believed that the use of hospitals depends not only on action by health-oriented staff but by a whole range of social services that support the family and provide substitutes for care by the family. It is also believed that, for certain patients, services can be developed to provide a higher quality of care in the home than can be provided in any type of institution.

According to this view the number of hospital beds needed depends not just on the number of people who could be treated or cared for in hospital but on the number who should be in hospital. It is believed that the hospital should not be overused, not only because it is so costly but because it is dangerous: in all hospitals there is a considerable risk of cross-infection. Unnecessary admission to a hospital may make the patient sicker and also make him think that he is sicker than he is. Moreover, the artificial community contacts of hospital visiting are no substitute for living in the community. The patient's involvement with the community is seen as part of the quality of patient care.

Thus the need for hospital beds depends on what alternative arrangements are available for the care of the patient. This depends in part on how far relatives and others are prepared to care for the sick at home and on the services provided to assist them to do so. Are doctors, nurses, occupational therapists, physiotherapists, and others available to provide services in the home? Are there staff to help with cleaning and cooking, or can meals be delivered to the home? Are there neighbors or paid staff available to look after the patient while relatives go out in the evening or go away for holidays? Are there nursing homes for a patient while relatives are away for any reason or unable temporarily to provide care?

Much also depends on the suitability of the home for the care of the short-term or long-term sick. Can ground-floor accommodation be made available with convenient bathing and toilet facilities? Can the home be adapted by installing hoists, rails, and ramps and by widening doorways to take wheelchairs? Nor is care in hospital the only alternative to care at home. People who need care—those, for example, who are mentally handicapped or suffering from depression or senility—can be boarded out with people paid to look after them in their homes or housed in flatlets or grouped housing where a warden can keep an eye on them and provide support and services. Alternatively, they can be cared for in hostels. The hospital is therefore seen as at one extreme end of a variety of care institutions and should be used for tasks that cannot be done elsewhere or that only the hospital can do at reasonable cost.

Much will depend on who pays for what when the choice is made between care at home and care elsewhere—on the incentives for those who decide or influence the decision. Much also will depend on relative costs wherever they fall. Much will depend on the preferences and attitudes of both the patient and the relatives and on who interprets them. Ultimately a choice must be made after assessing the burdens, calculating the costs, and weighing the risks. Do physicians in the United States see it as their task to present these choices? Are these choices available? Are there agencies to make them available?

In terms of the fundamental values of medicine, or at least my values of medicine, it becomes artificial to attempt to draw hard and fast lines between health care and social care. Some people clearly need health services, others only need social services, but many need both. Requirements may often shift radically on a day-to-day basis. Yet in many countries of the world the pattern of services and the financing of services—particularly health insurance—is based on three unstated assumptions: That health institutions and social services can be clearly delineated, that preventive medicine can or should be separated from curative medicine, and that cure rather than care is the overwhelming need of Western nations. There is an unwillingness to accept the fact that for many the prospects of cure are limited and that, with an aging population, the quality of

care and support is the most important requirement for the chronic sick and disabled.

Structuring of primary care.—The key to the proper use of hospital beds is not more and more regulation through hospital records but a strong and organized system of primary care closely coordinated into a wide range of related services. The essence of primary care is continuity of relationship so that knowledge is acquired of each patient's medical history and family setting, and possibly his occupational setting—all of which may be relevant for the patient's health care and for helping to assess where that care can most appropriately be provided.

The role and training of the primary doctor or general practitioner has been hotly debated over the past few decades. Some have argued that much of what a general practitioner does could be done by someone with less training. But extensive education and training are needed to decide when specialist care is required and from what specialty, to advise on the practicability of care outside hospital, and in general to assess what services are needed and see that they are provided. In particular, a physician is needed to select and mobilize a package of services for care at home. Without authoritative leadership, the alternative of care at home will go by default. Thus I believe that general practitioners need every bit as much training as is needed for any specialty and they also need staff working closely with them to whom particular tasks can be delegated.

First of all, a primary doctor needs nursing staff to assist him in his consulting room and also to visit his patients in their homes—not just to provide nursing services but to assess when further visits from the physician may be required and to train relatives to provide simple nursing care when the nurse is not present. Second, he needs staff to help him with preventive work and discover patients who may need services but are not receiving them. Third, he needs a supporting staff to arrange, on his behalf, for whatever further services a patient may require.

This managerial work in primary care, like other managerial work, does not lend itself to fee-for-service payment. For the services that are of critical importance to patient care are communication with others on behalf of the patient—explaining the patient's needs to the occupational therapist or physiotherapist, discussing the case on the telephone with the specialist, and explaining why priority should be given in the assignment of domestic help. Whether these tasks are actually done by the doctor himself or by his staff, they are not tasks for which standard payments can satisfactorily be made. Fee-for-service payment encourages the doctor to see his role in terms of tasks that bring reward—the consultation, the diagnostic test, the treatment procedure. The task of arranging for the home care of the patient may be much more time-consuming—time for which a fee schedule cannot appropriately provide.

Moreover, the concept of social care does not fit happily with fee-for-service payment. Here the task of the physician is not to deliver procedures but deliver emotional support—to comfort the dying, to prepare women for widowhood, to teach people how to live with a disability, to accept the consequences of aging, and to give comfort to distressed relatives. These were tasks that, in an earlier age, we looked to the church to provide. Some still look to the church; others expect these services from their physician. Can we program our cost-regulatory computers to accept fee claims for tender loving care? Or must the physician provide it free and at the sacrifice of time that could be spent in services for which he could readily claim? The fundamental question is whether it is the task of the physician simply to perform medical acts or to deliver comprehensive health care.

Nor does the concept of heading a domiciliary team readily fit with private practice. In many countries, home nursing is underdeveloped and when it exists it is a service wholly separate from the doctor. The home nurse is expected to communicate with the doctor in writing or by telephone, yet the doctor may not know the nurse personally. The nature of home nursing is such that unless the patient has a whole-time nurse, the nurse is unlikely to be present when the doctor happens to visit. In the hospital setting the nurse makes it her business to be present when the doctor visits, and mutual confidence and effective teamwork is encouraged by these regular meetings. Similarly, it is much more satisfactory for home nurses to work with a particular doctor or practice to ease communica-

tion and simplify the task of seeing that patients who need nursing help receive it rapidly. But the nurse needs an office from which to work. If she goes on holiday or is sick, a replacement must be found quickly. These problems are more readily solved if both doctor and nurse are part of a wider organization that provides accommodation and pays for all expenses.

Working Toward Economy and Quality

For all these reasons I advocate a structured system of hospitals and of primary care as mechanisms for promoting economy and quality in the wide sense that I have indicated. A system of organization may or may not work as it is designed to work, however. How is it possible to generate incentives for economy and incentives for quality? Economy can be imposed by limiting budgets and scrutinizing bills, but, if each hospital is given a separate budget, incentives can be distorted. The hospital can curtail its costs by treating fewer patients, admitting less severe cases, or treating cases less intensively. A reduction in length of stay and more admissions to maintain occupancy would generate greater costs than the annual budget could cover. Indeed, no hospital may be able to attain maximum efficiency because its budget is insufficient for it to do so. Thus it is preferable to have one budget for all hospitals serving a defined population. But separate budgets for hospital and nonhospital purposes obstruct the process of finding the appropriate balance between hospital and nonhospital services. It is for this among other reasons that the British National Health Service has been reorganized to provide one regional budget out of which comprehensive health services are financed.

HMO's as answer.—The same type of thinking underlies the concept of the HMO's, though the scope of HMO services is much narrower. HMO's are currently seen as the American answer to value for money in medicine. Yet surely much must depend on how they are operated and who controls them. Here I would like to raise some questions about HMO proposals that I think many other European observers might ask.

Are competing HMO's to have their own hospitals in the same area? If so, would that not either result in the uneconomic duplication of facilities or else generate greater travel costs for hospital users? If HMO's are competitive, could not this lead to an undesirable emphasis on amenity and convenience at the expense of economies in those services, the importance of which patients are not aware?

If the services offered by different HMO's are available at varying prices, might not the better-off choose the more expensive contracts on the assumption that they *must* be purchasing better services? Will such choices frustrate the pressures for economy that competition is expected to generate? If organizations are allowed to select their members, premiums will presumably become risk-rated. Will high-risk users be forced to pay high premiums or find their health services elsewhere?

Would not competition between organizations lead to competition for scarce resources so that geographical distribution of health services could become even worse than at present? This seems more likely to happen if doctors shared all or part of the profits of HMO's. Moreover, would it not place too heavy a strain on medical ethics if doctors were placed in such a position that every dollar of expenditure they authorized for patients affected, dollar for dollar, their own remuneration?

Most of these problems would be avoided if only one organization were responsible for providing health services for all in a region of some 1–2 million people. I realize that this involves the removal of certain aspects of choice to which so much importance is attached over here, even though it is acknowledged that the user is not well-equipped to exercise such choices. It also involves entrusting one monopoly organization with substantial power. Even if choice were sacrificed, there would still be the risk that resources might be heavily concentrated in the richer areas and in areas where professional people prefer to practice—unless manpower ceilings were set for each region for different categories of scarce personnel. Health insurance can provide money, but it cannot ensure that there are doctors, dentists, nurses, and other health manpower wherever that money is spent.

Regional budgeting.—I personally believe that

regional budgeting accompanied by regional planning and central control of posts for scarce personnel provides the best available answer to the problem of creating a setting where quality, economy, and equity can be promoted. Those who control the burget are thus forced to make choices in the use of that budget between hospital care and out-of-hospital care; between finding those who need but do not demand and those for whom demands are made, some of them unnecessary or of low priority; between the prevention of ill health and the cure of ill health; between standards of amenity and care and valiant efforts to cure or keep alive that have no serious prospects of success; and between high standards of care for those who can appreciate it and technical survival for those who cannot.

New Incentives for Decision Makers

Who should make these choices? In the last analysis, whose values should prevail? How can an effective working relationship be established between representatives of patients, representatives of those who bear the costs, and health professionals? How can lay representatives be found with the judgment to know where it is proper to overrule professional opinion in establishing broad priorities and when professional opinion should always prevail?

Information system.—At the very least, we need more information about levels of health in different social and occupational groups, the activities of health professionals, and the results of those activities. Despite the vast resources devoted to health services, extremely little information is currently available that relates the use of health resources to health benefits in any sense. While some doctor may come to know of a patient's death, disability, or recovery, he may not know who took the critical decision in the patient's management. While death and recorded causes of death are carefully registered, this information is not systematically related to past patient management or to the use of health resources on the care of that patient. Rarely is the clinician able to compare his performance with that of his colleagues in a systematic way, standardized for diagnosis, severity, age, and other variables. New treatment procedures are still often introduced before their value has been meticulously evaluated.

What is needed is a system of information that shows those who make professional decisions, the results of those decisions, and the resources used to achieve these results. This information should also be available for independent professional review. This seems to me the constructive use of computerized information systems rather than the examination of medical acts against medians and means. A number of people have been working on this type of problem over here as well as in Britain[8] and elsewhere.

Responsibility of health care workers.—Better information will not necessarily be enough to to change behavior or improve the quality of decisionmaking so that unnecessary costs are avoided and quality care in its widest sense promoted. Thus, ultimately, we must look not just at the financial incentives on those who operate our health services, but at their ethos, their commitment, and at what gives them satisfaction in their job. Here I am thinking not only of physicians and dentists or administrators and managers but of nurses, social workers, and paramedical workers. We will not get value for money in health care until health professionals see it as part of their responsibility to see that we do.

This has major implications for the original education and continuing education of those working in our health services. It has major implications for the selection of those who are educated and trained and for those who provide that education and training. The health professionals must accept their responsibility for using health resources effectively and efficiently or the immense power we currently give to the health professions may be challenged and part of it transfererd to others. This would, in my view, be the wrong solution.

CONCLUSION

The central questions are not so much of value in its narrow sense but of social value in its widest sense. We are not just concerned with the justifi-

[8] See, for example, B. Abel-Smith et al., *Accounting for Health*, King Edward Health Fund, London, 1973.

ability of medical acts and the price tag they should carry. Nor are we simply concerned with the technical quality of the services rendered by teams of professionals. We are concerned with equity in the distribution of health resources, with their deployment in the promotion of health, and with the integration of health and social care. Value for money in this last sense cannot be achieved by fragmented providers or pluralistic financing agencies. Somehow a socially responsive organization is needed that can mobilize the resources needed to promote these values.

Notes and Brief Reports

Disability Beneficiaries Eligible for Medicare*

On July 1, 1973, an estimated 1.7 million disability beneficiaries became eligible for Medicare. The Social Security Amendments of 1972[1] extended Medicare coverage, effective July 1, 1973, to persons under age 65 entitled to cash disability benefits under the social security or railroad retirement programs because they were disabled. Coverage was limited to beneficiaries who were entitled to disability benefits for at least 24 consecutive months. (The amendments also extended coverage to persons under age 65 with chronic renal disease if they are insured or entitled to benefits or are the dependents of such insured person or beneficiary.)

This report presents preliminary data on disability beneficiaries who were eligible for Medicare as of July 1, 1973. Data for disabled persons entitled to hospital insurance (HI) are reported by age, race, sex, and State of residence. Future reports will carry complete data on these beneficiaries as of July 1 of each year.

SOURCE AND LIMITATIONS OF DATA

The data reported here on disability beneficiaries eligible for Medicare on July 1, 1973, were drawn from the master beneficiary record of the Social Security Administration's central office. In April 1973, 1.7 million persons were identified in the master beneficiary record file as eligible for Medicare on July 1. Excluded from this number were 27,188 railroad retirement disability beneficiaries because they have Medicare coverage under the railroad retirement program. An estimated 6,000 beneficiaries with foreign addresses were excluded because detailed information was not available. Also excluded were about 9,300 beneficiaries under age 65 who were eligible for Medicare on July 1, 1973, solely because of chronic renal disease.

This report discusses only those eligible beneficiaries entitled for at least 24 consecutive months to cash disability benefits. It is estimated that disability beneficiaries covered under Medicare represent 73 percent of all persons currently receiving disability benefits.

Like beneficiaries aged 65 and over, the disabled beneficiaries who are eligible for hospital insurance may elect coverage under supplementary medical insurance (SMI). The eligible disabled beneficiaries were therefore automatically enrolled for both programs (except for those living in Puerto Rico, other outlying areas, and foreign areas). Since supplementary medical insurance is a voluntary program for which beneficiaries pay a monthly premium, the person coming on the hospital insurance rolls may indicate that he does not wish to be enrolled under the medical insurance part of Medicare.

In April 1973 the Social Security Administration notified 1,662,000 disability beneficiaries living in the United States that they were entitled to HI and were being automatically enrolled for SMI as of July 1, 1973 (table 1). They were sent enrollment information about Medicare and a form to be returned no later than June 30, if they did *not* wish to be enrolled for SMI. By the last week in June, 143,000 eligibles indicated that they did not want SMI. About 35,000 eligibles living in Puerto Rico, where the refusal rate was ex-

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[1] For a complete description, see Robert M. Ball, "Social Security Amendments of 1972," *Social Security Bulletin*, March 1973.