

# Sailing without radar: An excursion in resource allocation

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## Abstract

*This paper deals with the knowledge base employed in resource allocation. It deliberately distinguishes between 'thick-textured' and 'thin-textured' knowledge. A thick-textured view of change in the health sector accounts for the history, civic goods and variety of human needs and passions which rationalist economics defines out as a thin-textured matter of individual choices in a free market.<sup>1</sup> The narrative material begins with a discussion of health service policy-making in South Australia and elsewhere in the 1980s and 1990s, then proceeds to a discussion of priority-setting literature, which we regard as thin-textured. We offer two accounts of approaches to setting priorities in health care which we think have overcome some of the deficiencies of the thin-textured approach.*

## Introduction

In 1986 South Australia went nostalgic in celebration of 150 years of white settlement. With generous government subsidy, the tramp ketch *Failie* was refurbished to sail tourists around South Australia's gulfs and islands. If you stand on the deck of the *Failie*, it appears that the boat tacks its way on the shifting winds between the stationary islands. If you hunch over the radar screen in the chartroom, it appears that the islands shift and weave: the radar is egocentric, focusing the world in the form of its own technology. Sailing the choppy seas of resource allocation, you might imagine the structures and institutions of health service provision as a ketch and the technologies of economics as an egocentric radar ...

## **A short history of health service policy-making**

Australia has not been alone, amongst western economies, in expressions of concern about the ‘explosion’ of health care costs since 1980. Even when appropriate discount is made for the ageing of populations, the change of acute chronic illness and the steady displacement of labour, in the form of care, by capital, in the form of technology, there has been some real increase in the proportion of total resources allocated to health care. This has been spectacularly obvious in the United States and, to a lesser degree, in the United Kingdom and Australia. In several Australian States, many small hospitals were established by local initiative before 1940, then sustained by government subsidy. In South Australia, a gerrymandered electoral system magnified the political influence of the ‘voluntary’ hospitals’ demands for subsidy, but the State manipulated federal funding arrangements astutely enough to limit the impact on its budget overall (Hicks 1987). Eventually the State’s declining economy and declining and ageing population, relative to the rest of the Australian federation, provoked tentative efforts from early in the 1980s to manage and then contain the pattern of spending in health service provision.

In that context there was inconclusive discussion amongst appointed members and senior management of the State’s Health Commission about the need to reduce the number of beds in teaching hospitals generally, and to bring under more centralised management the work of the separate Adelaide Children’s Hospital and the Queen Victoria Hospital for Women in particular. Before the end of the 1980s, the State’s community health services, relatively privileged by Australian standards, were also being pushed towards rationalisation of their services and management structures.<sup>2</sup>

The broad economic history of hospitals during the past generation has been described neatly in two articles about American hospitals. Hospitals were once slow-stream workshops for doctors, with average length of stay in double figures, a place for several days of observation and some diagnosis to decide upon a treatment and prepare the patient’s resistance for it, and to protect the patient during convalescence. The dramatic decline of length of stay in hospitals has been marked by decentralised diagnostic technologies, operations very soon after admission, and discharge as soon as possible after procedure. Hospitals have attempted to deal with their changing function by changing the corporate organisation of the hospital, by changing workplace culture to one of industrial efficiency, and by changing their market position (Steckle 1995).

These changes have occurred in the context of an intellectual retreat from public expenditure in support of welfare goals and a pervasive rhetoric of cost

containment and retrenchment. Retrenchment has been a slippery slope for the hospital industry marked, in the United States, by progressive reliance upon price discounts, then stricter forms of utilisation management and, eventually, capitated payment (Shortell et al. 1995). During the past 20 years, intellectual forces similar to those which informed cost containment have sustained the rise of epidemiology. In the early 1980s, in the United Kingdom and Australia, there were several attempts to rationalise hospital expenditure by allocating resources on the basis of demographic characteristics (Hicks 1985). A decade later, the New South Wales Health Department, the largest in Australia, has moved, ostensibly, to an epidemiologically based, regionally organised system of health administration (New South Wales, *passim*; Rissell et al. 1996).

The New South Wales approach has invoked an American suggestion that:

*caring for a population is best done within a defined geographic regional market and that management and government structures are probably best located at these sites* (Shortell et al. 1995).

However, New South Wales does not appear to have embraced the American consequence that:

*to assess community-wide health status needs, systems will have to go beyond analysis of existing secondary data on population demographics and disease trends to include primary data collection, information on prevention and health promotion services, interviews and focus groups with citizens and community leaders and linkage of 'illness' and 'community well being' data similar to that collected by environmental health agencies and related units* (Shortell et al. 1995).

'Community-wide' approaches have a potential to obscure, as well as to focus, the view. Epidemiologically, the concept of community is useful in that it goes beyond the empiricism of 'I saw a similar case, once' or 'the tonic usually seemed to fix my last patient' to try to understand the broad patterns of the incidence of disease and the effectiveness of interventions to prevent disease or promote health. However, a merely epidemiological approach also runs some risk of summarising and simplifying to the point where sub-populations are averaged out of sight. As studies of inequalities in health continue to show, 'The Public' is made up of many publics whose experience is distributed widely around the average (Benzeval et al. 1995). In the civic sense, the concept of community goes beyond empiricism by recognising that the political structures and relationships of sub-populations are significant for the way health problems emerge and whether interventions for health succeed.

Those sub-populations are important for resource distribution and the allocation of effort in health services in two ways. Firstly, if health problems are distributed differentially, effective response to them will require differential distribution of money and skills. Secondly, if resource distribution is as much a civic as a technical matter, then the formation of opinion in sub-populations also needs to be understood, as feminist philosophers have begun to point out: 'Public life in egalitarian, multicultural societies cannot exist in a single, comprehensive public sphere' (Fraser 1993). There must be, as there have always been, zones of comfort in which single parents or carers for children with disability or women at risk of being labelled hysterical can encourage and train each other to have their say in the debate about what kind of society they want to live in and how such a society will share its resources. Onora O'Neill, considering 'justice, gender and international boundaries', argues that the disempowered are at risk of injustice (and, we would add, the Inverse Care Law of health services will apply) 'unless institutions are structured to secure the option of refusal or renegotiation for those whose capacities and opportunities are limited' (Hart 1971; Hart 1988; O'Neill 1993).

## **Sounding out opinion**

In general, the structures for seeking opinion offer little option of renegotiation – with the possible exception of some elements of the 'Oregon experiment' (Campbell 1991; Dougherty 1991). Efforts to discover what 'the community' wants from health services generally have not broken out of the strait-jacket of methodology in which the most 'efficient' work involves approaching selected individuals with a set of prescribed questions presuming discrete answers (Mooney 1994, 1995; Mooney & Lange 1993). Survey-by-completing-the-form approaches tend to suppress variability because they presume that individuals chosen by randomisation and confronted with a standardised questionnaire produce homogeneous answers which can be rolled together to produce a population average. Just as modern economic rationalism assumes, invalidly, that the sum of actions taken to satisfy individual preferences is revealed by what 'The Market' 'does' – or, even, 'thinks'! – so the market survey is thought to reveal 'what the community wants': the invisible hand of the market guided by the invisible mind of the market survey.

The salient from health economics into opinion surveys is not surprising: both rely upon an individualist form of utilitarianism some distance from the earlier social utilitarianism of JS Mill (Williams 1973). The perspective is inadequate descriptively, practically, psychologically and politically. Descriptively, it is too thin to make ethical sense: it presumes triggers for human wants and satisfactions

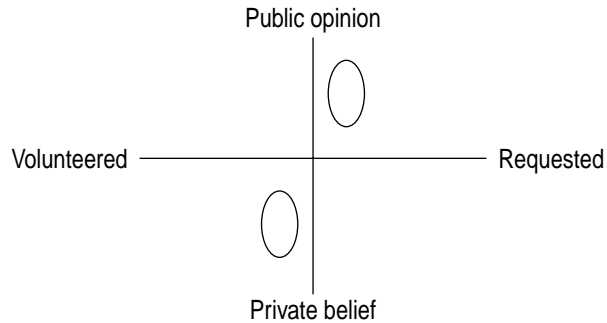
far simpler than those which cause the dilemmas that ethics or political philosophy have to resolve (Anderson 1993). Practically, it is too thin to sustain the kind of use to which it might be put in, say, health promotion. For example, proposals to coerce parents into having their children immunised, current in Australia, presume a utilitarian stimulus–behaviour reaction but ignore the wide gap between the knowledge frames of public health scientists and of parents worried about uncertainties in general. (*Do you think children should be immunised before admission to school? YES / NO?* may miss the subtlety of *Yes, but ... my sister's cousin's little boy had a bad rash after the doctor gave him a needle ... And, anyway, our Minister says you shouldn't interfere with the body.*) No doubt many people who have been opinion-pollled can recall the frustration of having their careful qualifications and their grasping for reasons reduced to a 'Don't know' or an 'Other'. The 'ifs and buts' which are built into opinion and the discomforts which can be lost to view in a polling summary begin to be obvious.

The third deficiency of the market survey is in terms of social psychology. Recent writing about ways of understanding public opinion is critical of opinion polls on the grounds that:

*the superficial probes necessary for an enumeration of several hundreds of citizens dispersed over a wide area cannot ... capture some fundamental attitudes. The relentless counting of surface opinion ... ungrounded in either the context of surrounding circumstances or in some basic psychological attitude-set, debases the exercise ...* (Goyder 1985a).

The weaknesses of the survey apply, especially, where it goes beyond matters of fact to questions of opinion: in that realm, unless exceptional care is taken, the sample survey is more likely to confirm what the surveyors expect than to provide them with new understanding (Goyder 1985b).

The strength and weaknesses of various approaches to the sounding of opinion are illustrated by a diagram derived from Morgan (1988):



In this image, ‘public’ opinion is a personal expression already harmonised to the way a topic is being talked about in the media, on public transport or in the tea-room. ‘Requested’ information is confined to categories (and, perhaps, language) laid out by the interviewer and ‘volunteered’ information is more likely to represent categories and language held privately. The door-step interview will occupy space predominantly in the north-east quadrant of the image; the focus group will be in the south-west quadrant. Morgan also points to the way in which people form their views, giving an interesting example from his experience with focus groups exploring beliefs about heart attack risk factors and about widowhood:

*an emerging discussion in a focus group is in many ways analogous to the process of schema or perspective formation in an individual. The group begins with relative uncertainty about the extent to which participants share a common set of perceptions on the discussion topic. As more members of the group present their experiences and perspectives on the topic, they typically find some common means for representing areas in which they both agree and disagree; they may ultimately come to some further realisations about the sources for their various levels of agreement and disagreement (Morgan 1988).*

Similarly, Bellah et al. (1985) showed that the door-step opinion poll merely takes a moment-in-time snapshot of a continuing process by which a variety of traditional, secular and religious concepts and values are re-worked in the minds of Americans.

Finally, the opinion survey simply does not work in political terms. The most recent writing in political theory shows that poll-driven politics – or, worse, the

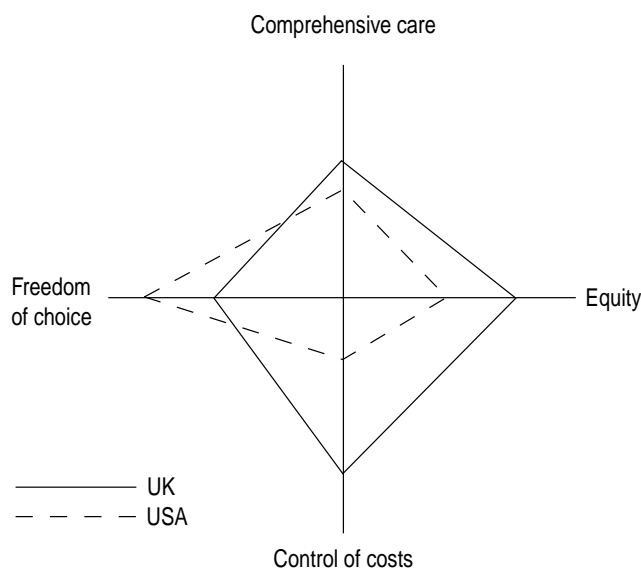
sampling of talk-back radio to decide 'policy' – actually reduces governments' scope for policy initiative (Brennan 1993; Goodin 1993; Pettit 1993). In addition, the attempt to make policy is gutted by the plebiscite effect. Media thrive on the exotic and the novel: the tabloid newspaper will always present the miracles of facial reconstruction as a front-page picture and lead story before something as mundane as encouraging teenage mothers-to-be to use prenatal care. Presuming that media do have a substantial effect on public opinion (Morgan's north-east quadrant), however, no government can be sure that it 'knows what the voters want' because the next plebiscite will reflect the next exotic, novel technological innovation. That way lies a desert for any effort to contain the cost of health care delivery.

### **Consulting, not surveying**

A short history of some local activities in South Australia helps to illustrate the argument about politics, economics and ethics. In the early 1990s several groups, including the South Australian Council of Social Service, the Community Health Association, the Consumers' Health Forum and the Social Health Office of the South Australian Health Commission, felt the need for an informed constituency as resources for health became more constrained. They set up a series of meetings which were originally called Health Dollar Seminars. In all the seminars, information was presented and explained about the sources of funds for health care, the patterns in which they are spent, and the relation between that spending and health status. The initial seminars relied on a matrix analogous to that which had been used in the Oregon debate, essentially requiring oppositional choices between competing technologies of medicine. For example, people were asked whether they wanted care for grannies or care for neonates; and within the grandparent population whether they wanted preventive, rehabilitative, or acute or chronic services.

This approach proved to be problematic in that women were less willing than men to make exclusive judgements about resource allocation, and men and women were less comfortable deciding what services and commodities should be excluded from the suite provided than they were ranking services which might be added. The oppositional matrix approach also proved to have a rather arid impact, reducing the discussion to a competition between one locality and another for professionally and bureaucratically defined goods such as a new hospital there, an upgraded piece of equipment here, and so on. To counter that difficulty the seminar leader began to use a 'vector sum of values' approach which had been used in the United Kingdom to give expression to differing emphases on the competing values of choice, equity, cost control and comprehensiveness

(Weale 1988). Weale's version plotted, for illustration, the differing values of the American and the United Kingdom health service systems:



It does not matter where the points on the axes are located with absolute precision: the diagram merely served as a starting point for discussion as to whether members of the South Australian seminars wanted a health system which reflected more or less of any one of those values.

After three Health Dollar Seminars, the convenors began to realise that the emphasis upon the *dollar* endorsed the presumption of fiscal scarcity. In addition, the seminars had begun to show that people were not merely individualist in their attempt to map the competing values. Therefore the working title was changed from Health *Dollar* to Health *Issues* and the questions also began to change. Where the Health Dollar Seminars had presumed an order of questions from what kind of medical goods to what kind of health to what kind of life, the Health Issues Seminars reversed the questions, asking what sort of world members of the seminars would like ('What would the Good Life involve in this locality?'); what place health would have in that conception of the Good Life, and what role medicine would take within health. This coning of the argument from general questions of welfare to particular issues of medicine is the reverse of the more usual way of ordering the three in a society where medical science is a dominant source of values.

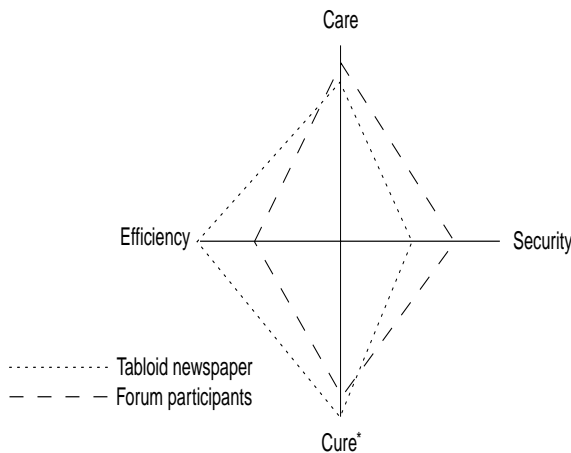
The shift of emphasis brought more reflective responses from people attending the seminars. For example, in a quiet moment in one South Australian rural seminar a young man said:



*Well, our daughter was saved by a neonatal care unit. I'm deeply grateful for that. But if you asked me as a matter of policy, I don't think that I would say that that's the most important thing to have in this town.*

At this stage, also, people who had enrolled for forums began to be sent questions based on an earlier focus group which had explored the relative strengths of underlying ideas about vitalism, professionalism, managerialism, economism and utilitarianism in the construction of the Australian health care system. Participants in the seminars brought the forms with them and a quick computation of the sum of their answers was fed back to the forum during the seminar. Participants were then asked to comment on the overall value picture which the sum of their individual answers appeared to indicate. Once again, there was a tendency, when confronted with the general picture, to say, 'Well, if that's what it produces overall, I'm not sure that I'd want to push my own demand too far'.

At about the same time, at a seminar in one of the larger rural towns in South Australia, people began to express interest in care for older women retiring from farms to the town, as distinct from the previously ritual statement about the need for the town to have acute care medical facilities as sophisticated as those in urban hospitals. That led to a revision of Weale's diagram to incorporate four different values to its axes, namely:



\*Cure is exemplified by doing whatever medical science can do to defeat the unexpected mid-life cancer or to save the premature baby. Care is exemplified by the desire to have a nurse available to call on grandma twice a week or a mental health worker available in the midst of the rural recession. Security is exemplified by the notion of maintaining immunisation so that children are not at risk, or of keeping the water pure or developing a local Air Care group or having reliable information about hazardous chemicals in a horticulture area. Efficiency recognises the usefulness of a degree of casemix (DRG) procedures to make practitioners more aware of the costs of relative services and may also involve lowering taxes and reducing health care spending.

The vector diagram of those four values proved to be a powerful ‘focuser of minds’ in the seminars.

In a subsequent third phase, of Health and Public Policy Seminars, the discussion was anchored around an image drawn from Nussbaum’s observation that it is common in Greek tragedy to have a central character, often the king, who proclaims that ‘the law must be upheld’ or some similar overriding value. He is committed to that principle above any other consideration but is surrounded by a chorus who say: ‘True, oh King, true: the law must be upheld. But this week we have to get the crops in and next week the kids are going back to school. Could we save law and order for the week after that?’ Nussbaum suggests that the kings are taking the Platonist line that somewhere there is a true principle which must be pursued irrespective of circumstances. The chorus represents an Aristotelian view that there is no good life but the one which we create out of a harmonious balance of our circumstances (Nussbaum 1986). In various planning groups and meetings of health and social welfare councils in South Australia in the most recent period, participants have been asked to consider who are the kings on the stages which they must tread: the State health minister, the Commonwealth bureaucrat, the regional director, the chief executive officer of the hospital or the president of the medical staff society? What truths do these characters proclaim: for example, the relative benefits of a locally useful hospital or an internationally famous one? What are the circumstances and passions of the chorus or constituency which the planning group believes it must serve; and how do they get a voice in the debate about the good life, health and medicine?

The South Australian experience suggests that, rather than settling for allocations based on 50% plus 1 of individual preferences, it is worth considering a pluralist approach which will say: ‘People of goodwill will support this range of allocations for these reasons ...’ The key ethical question then will be: ‘How can civic society hold open these varied evaluations and avoid conflict between the groups who hold them?’ Ethics and political philosophy both come from a tradition which holds that the primary task is as much to express the dilemma clearly as it is to settle the issue. Therefore education, which Morgan’s south-west quadrant privileges, is more important than inquisition, which is the mechanism of his north-east quadrant. The next section of this paper deals with the difficult problem of grounding value considerations of this kind in the life of a teaching hospital facing cost constraint.

## Refurbishing the good ship 'FOPP'

By 1995 the executive staff and the chiefs of service at the newly amalgamated Women's and Children's Hospital in Adelaide understood that their organisation could not continue to withstand the fiscal pressures of the State's rationalisation process without reducing the services it provided. They acknowledged that there should be a focus on technical or operational efficiency in providing services. They also believed that the organisation had a responsibility to allocate resources to those services judged effective in producing the health outcomes most valued by the public of South Australia. The second emphasis, on a broad civic responsibility in addition to the responsibility for the immediate user, appears to have been related to an emerging public health value base led by a chief executive officer and executive staff who had gained significant health management experience in community health services. Community health services in South Australia operated on a strong commitment to principles of equity and community participation in the planning and management of services and work practices. The public health ideology was largely supported by the chiefs of service (who had been recently appointed by the chief executive officer) and by the university professors of obstetrics, paediatrics and psychiatry who did their clinical research and teaching in the hospital.

There are, of course, tensions between individual goods and the public good, the resolution of which can be difficult due to the deeply held values that people have about health and even human nature. Those tensions were not eased by the fact, while the hospital was considering the broader issues related to health resource allocation, the South Australian Health Commission, the hospital's dominant source of funds, was 'realigning' itself to become a 'purchaser' under the funder/owner/purchaser/provider model of health care administration. The purchaser/provider model, although enunciated in the United States, had developed in the United Kingdom and was gaining rapid acclaim in Australia for its ability to create an 'internal market' in the health sector (Day & Klein 1991; Enthoven 1991). The model rests on a market ideology which maintains that if the purchaser holds the funds and purchases what the state needs from the provider most able to supply the care at an agreed quantity and quality, the competition created amongst the providers will drive the price down and the quality up.

Although it was not politic to use the language of priority-setting, it was clear to the hospital leaders that some form of planning was required to determine the best 'purchases' for the resources available. The Health Commission appeared, then, to have no intention to significantly involve the providers of care such as hospitals in this process. However, the Women's and Children's Hospital undertook to develop a process for determining its own service priorities which

rested on some understanding of community values and an evaluation of the existing programs or services against those values. The hospital already had a strong commitment to community and consumer participation in planning services although, until this point, participation had been mainly in decisions about *how* to provide services. Decisions about *what* services to provide had been made by the hospital clinicians and administrators on the basis of historical budgets and incremental developments in technology.

The Health Commission's new Purchasing Office was simultaneously exploring the possibility of applying Program Budgeting and Marginal Analysis as a method to assist in determining priorities for health resource allocation across the State. This method rests on an analysis of the costs and outcomes of existing services compared with the marginal gains and losses of viable alternatives (Cohen 1994). Who should undertake that analysis and the criteria for defining what is a gain or a loss are fundamental to the ethics of the process, yet, aside from a valiant attempt at community participation by the (then) regional planning units, the Health Commission had not considered the texture of the process as anything other than the thin result of economic and cost analysis and market surveys of community opinion. The planning units had developed a process to train community members to participate in deciding what broad programs of health care should be increased and what should be decreased in the particular regions. Their analysis involved limited information on outcomes or need and did not involve professionals who provided care in the programs mentioned. Their report was disowned by the Minister as soon as it appeared and the planning units were closed as part of the Health Commission's realignment process.

The hospital had experience of consumer participation processes which demonstrated the possibility of a thicker texture of values and showed that relationships between consumers and providers could be more constructive and enduring than 'information sharing' or 'surveying opinions'. There was also a concern that surveying opinions on the level of priority to be given to the range of services provided by the hospital would suffer from the same weaknesses as the oppositional matrix in the Health Dollar Seminars and yield few useful results. The number of possible services was too many, their effectiveness for any individual patient dependent on too many factors, and the knowledge level of those being surveyed was too low. Furthermore, opinion survey results offer brief comfort: they cannot be sustained beyond each new technological or research development, which both modifies demand and brings to bear new information on effectiveness. They are also vulnerable to biased reporting in the public media which can highlight the exotic and the individual at the expense of other goods

(Chapman & Lupton 1994). The hospital executive was aware of the tension between the roles of the hospital to provide individual care, on the one hand, and to contribute to public health, on the other. It was clear that any analysis of community views needs to take this tension into account.

The hospital requires information on community and consumer values that is enduring and can be used to guide a range of decisions within programs of services and between programs. All services provided by the hospital (no matter which program they belong to) can be categorised by their objective which, generally, can be placed on a continuum including health promotion and health protection strategies; early diagnosis and treatment; services which assist people with an illness to be rehabilitated; services which provide self-care and improve quality of life; and services which aim to cure severe illness and disability or to prolong life. A definition of how people value each of these *categories* of service is probably more achievable and usable than an affirmation that people value a *particular* service within a category. Firstly, personal experiences of particular services are diluted and less likely to bias the consideration of the 'value' of health services; secondly, it is not necessary to know all the details of the service to think through the general objective underpinning its provision. Asking lay community members, including users of the services, to act as if they were the Board of Management of the hospital and make choices between services with different objectives would ensure that the participants considered the tension between individual and civic good.

The hospital leadership agreed that an appropriate method to understand these values should reproduce resource allocation scenarios and questions that had been debated in the past or that might realistically be debated in the future. It is important to provide consumer and community 'members' in such an exercise with access to expertise and information to the same degree as real Board members would have. The hospital is less concerned, for all the reasons outlined above, with the *choices* that community members might make in this context than it is with the *criteria* which groups of consumers and community members use in making their choices. If it is possible to detect, between groups of people, consistency in the criteria by which they believe resource allocation decisions should be determined, then providers might be able to apply those criteria in a range of decisions, possibly over a number of years, without the likelihood that they would break down in the face of specific technological refinement of appealing individual cases.

Since 1995 the hospital has been developing methods to understand, and reflect in its planning, those values or criteria considered most important by the community in the allocation of health resources. To this end, the hospital has

undertaken four processes: workshop discussions (with community members, health care workers, staff of the Women's and Children's Hospital); a survey of workshop participants; a survey of Women's and Children's Hospital chiefs of service and department heads; and a question in the South Australian Health Omnibus Survey. (A wider survey of the South Australian community is being contemplated.)

## Workshop discussions

A total of 69 people took part in five workshop discussions in 1995 to 1997:

1. Community members – metropolitan (17 participants)
2. Primary health care workers – metropolitan (14 participants)
3. Jamestown community members – rural (10 participants)
4. Jamestown primary health care workers – rural (7 participants)
5. Women's and Children's Hospital staff (21 participants)

The community workshop participants, although lay community members, were more informed about health issues than the average person in that they had been identified by community health services or general practitioners as having an interest in the area of women's and children's health. Primary health care participants included general practitioners, speech pathologists, physiotherapists, social workers, psychologists and community health nurses. The staff of the Women's and Children's Hospital were a cross-section of clinical and non-clinical staff from junior to senior level.

Workshops began with an information session outlining health funding issues in Australia, similar to the approach taken in the Health Dollar Seminars. Participants were then divided into small groups of 7 to 10 and asked to imagine that their group was the Board of the Women's and Children's Hospital required to make some strategic decisions about resource allocation. They were told that the Board had \$500 000 to spend and were considering service proposals that totalled \$883 784. The proposals, whose objectives were broadly consistent with the continuum of categories of services outlined above, were as follows.

1. To establish a bone marrow transplant service for children who do not have a compatible brother or sister donor. **Cost: \$330 000**
2. To establish a service for teenagers whose pregnancies are categorised as being at high risk of complication for both mother and infant. **Cost: \$115 000**

3. To establish a women's and children's Health Information and Resource Centre in the main entrance of the hospital. The centre would be responsible for coordinating, providing and marketing appropriate health education materials produced by departments of the Women's and Children's Hospital and by other health agencies, as well as information about services and resources which are available within the hospital and the wider community.  
**Cost: \$71 784**
4. To establish a chromosome testing laboratory which will allow the fetuses of women who are 35 years or older to be tested for Down's Syndrome and some other serious chromosome abnormalities.  
**Cost: \$197 000**
5. To establish a centre from which medical and rehabilitation appliances to support home recovery can be borrowed or hired by patients or their families.  
**Cost: \$170 000**

The groups were provided with realistic background information about each proposal, including the number of people to be served; the likely outcome based on available medical knowledge; and the likely outcome of not providing the service. The groups also had access to a senior paediatric and a senior obstetric specialist for information throughout the process. Each group was asked to decide which proposals they would fund and to identify the values underpinning their decisions.

There was a high degree of consistency across all groups in relation to criteria which the 'Be the Board' process revealed as most important in decision-making, namely:

- The service should be EFFECTIVE and EFFICIENT.
- The service should benefit the GREATEST NUMBER OF PEOPLE.
- PREVENTIVE and EDUCATIONAL qualities – the service should have the ability to produce long-term benefits.
- The service should enhance or improve QUALITY OF LIFE.
- The service should be able to be ACCESSED BY THE GROUPS WITH THE GREATEST HEALTH NEEDS.
- The service should promote INDEPENDENCE and SELF-HELP.
- There was a desire that services NOT BE DUPLICATED (lesser priority given to those services which were available elsewhere).
- The hospital should have the CAPABILITY to provide the service.

## Survey of workshop participants

The survey of workshop participants was a step towards gaining a clearer understanding of what community views might be in relation to the allocation of health resources. It was also a tool to assist in the validation of results obtained from workshop discussions, and to form the basis for development of a valid instrument for use in a wider survey of the South Australian community. Each participant in the workshop was given two questionnaires, one before and one after attendance at the workshop. The questionnaire before the workshops asked for participants' opinions in relation to possible Women's and Children's Hospital health care policies. Respondents were asked to rank six possible policies for health care in order of preference for investment of funds. The order of priority they gave, consolidated for all workshop groups, is as follows.

- 1 DIAGNOSE AND TREAT EARLY: Women's and Children's Hospital will invest in strategies to diagnose illness or health problems and provide treatment or care as early as possible to better manage a condition and to prevent complications.
- 2 MAINTAINING QUALITY OF LIFE: Women's and Children's Hospital will invest in treatment and services aimed at maintaining the quality of life for an individual with an illness or a health problem.
- 2 RESEARCH AND HEALTH PROMOTION: Women's and Children's Hospital will invest in research, public advocacy, health promotion and health protection strategies which aim to prevent health problems before they occur.
- 2 ACCESS TO SERVICES OF PEOPLE MOST AT RISK IN SOUTH AUSTRALIA: Women's and Children's Hospital will develop services for illnesses/conditions in association with other health service providers in regions around the State to ensure that people who are most at risk of illness have easy access to good care.
- 5 TREATMENTS AIMED AT CURING OR PROLONGING LIFE: Women's and Children's Hospital will invest in developing treatments for illness or health problems which aim to cure or prolong the life of an individual.
- 6 CARE OF DYING (PALLIATIVE CARE): Women's and Children's Hospital will invest in care of the dying and their families.

Despite the different constitution of workshops (community members, primary health care workers and Women's and Children's Hospital staff), all participants ranked very highly in their survey responses the policy that supported early diagnosis and treatment and preferred least the policy that related to care of the dying. Two interesting differences did appear, however, between the different workshop groups. The policy which supports ACCESS TO SERVICES OF PEOPLE MOST AT RISK IN SOUTH AUSTRALIA was given considerably less preference by staff of the Women's and Children's Hospital than by all other groups. While it was the most



preferred policy of the Jamestown primary health care workers, it was ranked second to last by Women's and Children's Hospital staff. Secondly, Women's and Children's Hospital staff ranked TREATMENTS AIMED AT CURING OR PROLONGING LIFE higher than community member and primary health care worker groups.

## Survey of senior hospital staff

The questionnaire which was provided to workshop participants also formed the basis of an interview of 17 chiefs of service or department heads of the Women's and Children's Hospital. Like workshop participants, these senior hospital staff were asked to rank the same six possible policies for health care in order of preference for investment of funds. There was a high degree of consistency between the orders of priority provided by workshop participants and senior hospital staff, the only difference being that senior hospital staff gave a lesser priority to the policy which supported research and health promotion. Respondents were also asked to indicate how strongly they agreed or disagreed with a number of statements involving competing interests for health resources, and to state the principles which were important in making these decisions. The five principles which were considered most important in making health funding choices are as follows.

1. The extent to which the service had a PREVENTIVE or an EDUCATIONAL focus.
2. The EQUITY of ACCESS to services. Services need to be wide-reaching and socially just.
3. The COST-EFFICIENCY of the service. Services needed to be both effective and efficient.
4. The degree to which the service provided the MOST BENEFIT to the GREATEST NUMBER of people.
5. Existing and potential QUALITY OF LIFE of sufferers/potential sufferers.

There was a high degree of consistency across all groups, and between workshop discussions and survey results, in relation to the principles stated as being most important in decision-making:

- 1 Diagnose and treat early.
- 2 Access to services of people most at risk in South Australia.
- 2 Maintaining quality of life.
- 4 Research and health promotion.
- 5 Treatments aimed at curing or prolonging life.
- 6 Care of dying (palliative care).

Rankings provided by senior hospital staff were more consistent with priorities given by community and primary health care workshop participants than were the rankings given by the cross-sectional groups of Women's and Children's Hospital staff involved in the staff-only workshops. Like the community and primary health care workers, chiefs of service and department heads ranked very highly the policy which supports ACCESS TO SERVICES OF PEOPLE MOST AT RISK IN SOUTH AUSTRALIA. Also in line with the views of community and primary health care workers, they ranked investment in TREATMENTS AIMED AT CURING OR PROLONGING LIFE lower than all others, with the exception of those services which invest in CARE OF THE DYING.

Chiefs of service and department heads were also asked to indicate how strongly they agreed or disagreed with a number of statements involving competing interests for health resources, and to state the principles which were important in making these decisions. The criteria which they considered most important in making health funding choices were as follows.

1. QUALITY OF LIFE resulting from the intervention.
2. Likely EFFECTIVENESS of treatment.
3. Health services should focus on as MANY PEOPLE AS POSSIBLE.
4. HEALTH PROMOTION and DISEASE PREVENTION should be a high priority.
5. The ongoing COSTS involved in many treatments.

Again, there was a high degree of consistency between senior hospital staff and the community and primary care workshop groups in the criteria considered most important in decision-making.

The questionnaire administered to participants following the workshops was designed to ascertain whether they agreed, as individuals, with decisions they made in their groups: in all but one instance they did.

## **Question in the Health Omnibus Survey**

Another strategy to gain an understanding of the value placed on the categories of service by a broader cross-section of the South Australian community was the inclusion of a question in the Health Omnibus Survey, conducted at least once a year by a market research company in conjunction with the Behavioural Epidemiology Branch of the Health Commission. Each survey involves a representative sample of 4200 households, with 75% of the sample being selected from metropolitan areas of Adelaide and the remainder from country areas with a population of 1000 or more. Standard demographic and social indicator data

are included in each round, together with a bank of questions about specific health issues, interventions and so on. The survey is designed to facilitate research by the State's health organisations by providing them an opportunity to include questions within the survey. In late 1996 the Women's and Children's Hospital included a question in which respondents were offered the following prompt card.

### Prompt card

1. INVEST IN HEALTH PROMOTION AND HEALTH PROTECTION STRATEGIES WHICH PREVENT ILLNESS BEFORE IT OCCURS.
2. INVEST IN SERVICES FOR ILLNESSES WHICH HAVE THE LARGEST NUMBER OF SUFFERERS.
3. INVEST IN SERVICES WHICH DIAGNOSE ILLNESSES AND PROVIDE EARLY TREATMENT.
4. INVEST IN SERVICES WHICH AIM TO CURE ILLNESS OR PROLONG THE LIFE OF INDIVIDUALS WITH SEVERE ILLNESSES.
5. INVEST IN SERVICES WHICH ASSIST PEOPLE WITH AN ILLNESS TO BETTER LOOK AFTER THEMSELVES INDEPENDENTLY.

Having seen the card, participants were asked to nominate the one or two areas in which they would most like to see further money invested for people's health. The most important areas to the majority of respondents were:

- HEALTH PROMOTION AND HEALTH PROTECTION STRATEGIES WHICH PREVENT ILLNESS BEFORE IT OCCURS (cited by 63.0%)
- SERVICES WHICH DIAGNOSE ILLNESSES AND PROVIDE EARLY TREATMENT (56.4%)
- SERVICES WHICH ASSIST PEOPLE WITH AN ILLNESS TO BETTER LOOK AFTER THEMSELVES INDEPENDENTLY (31.1%).

There were several minor differences when the findings were analysed by the age of respondents, but the main order of importance remained unchanged. It is interesting to note that the proportion who thought that investment should be made in SERVICES WHICH AIM TO CURE ILLNESS OR PROLONG THE LIFE OF INDIVIDUALS was highest amongst the youngest respondents (15–24 : 25%) and decreased with age (65+ : 13.6%). The proportion who thought that investment should be made in HEALTH PROMOTION AND HEALTH PROTECTION STRATEGIES WHICH PREVENT ILLNESS BEFORE IT OCCURS did, however, increase with the level of education of respondents. The proportion was lowest amongst those with the least education (48.0% of those still at school and 53.9% of those who left school before 15 years) and highest amongst those with the most education (86.5% of

those with degrees). However, the order of importance did not vary with the level of education of respondents. The proportion who thought that investment should be made in HEALTH PROMOTION AND HEALTH PROTECTION STRATEGIES WHICH PREVENT ILLNESS BEFORE IT OCCURS was higher among metropolitan residents (65.5%) than among country residents (57.3%) although, once again, the order of importance did not change. The proportion who thought that investment should be made in services WHICH AIM TO CURE SEVERE ILLNESS OR PROLONG LIFE was higher among country residents (20.6%) than among metropolitan residents (17.0%). Taken overall, the Health Omnibus Survey results provide some evidence that the themes identified as important in decisions about resource allocation for those community and hospital staff who participated in the workshops were relatively consistent across a broader sample of the public who were asked to consider the same broad issues.

The work undertaken so far in the Women's and Children's Hospital planning and priority-setting project has begun to identify some consensus around criteria considered important by community members in the allocation of health resources. Attempts to gain a thicker textured analysis of values held by community members about the allocation of resource to health services have had an impact on the hospital, in ways not always predicted.

First the inherent professional fear that the community would be a Luddite mob has been addressed. Hospital staff who were present during the community workshops were so impressed with the work and the debate of the 'Boards' that they became convinced that this qualitative research method was the only valid way to ensure that the information on values was usable. The use of the qualitative research method, replicated and thereby validated through an iterative process over a reasonable period, was considered worth pursuing: there is far more fear of a 'thin' survey technique. The information exchange between the staff and the community members made possible by the method was considered absolutely necessary by the community workshop participants who valued the opportunity to be involved as well as the time devoted by the doctors to gaining their views.

Second, it was evident to all concerned that community members (even those who participated in a more recent workshop and whose children have potentially incurable illnesses) are not necessarily self-seeking individualists when asked to make decisions for the good of a whole community. The fact that the results of the deliberations of community members and consumers and hospital staff were so similar, and that the community members were so serious in their search for the best decisions for the State, has given comfort to the staff that they are not alone in their struggle for better health. It was agreed by the hospital chiefs of service that all participants in the workshop should be invited to participate in

a later search conference to define the role of the hospital in South Australia's health and the criteria by which resources should be allocated in line with that role. That conference was a major step towards making priority-setting far more explicit than is currently the case.

## Conclusion

The emerging clarity on criteria for evaluating service expansion and detracting can now be placed within a Program Budgeting and Marginal Analysis context. The hospital has begun a project to identify the broad programs provided and the services or sub-programs within each, and has begun to identify what should be expanded to maximise gain according to those criteria and what should be reduced to minimise loss against those same criteria to pay for the expansions. The criteria themselves will continue to be reviewed in the light of continued dialogue between the hospital and its community.

There might be both academic and applied benefit from efforts to determine whether variation in outcomes is produced if:

- the services are changed even if their broad objectives (as defined by the categories outlined above) are similar, or
- the facilitators are changed, or
- the participants are changed (for example, all men, all women, all old people, all young people, hospital patients, all non-patients, members of specific cultural groups).

However, the reality of health care decision-making dictates that we cannot wait for the perfect research work. Decisions are being made every day about which services to offer or not offer a patient. The question relates more to how well-founded these decisions are rather than to whether they are being made. The Women's and Children's Hospital is making an explicit attempt to anchor this decision-making in values about health supported by a broader community or interest than its own staff. Program Budgeting and Marginal Analysis can provide a tool to assist in resource allocation decision-making, but without knowledge of the thicker texture of real-life community concerns about health and health service issues, the tool is like a radar, egocentric and giving false impressions of life. Developing an understanding of the thicker texture of people's values can provide information to act as a beacon to doctors and administrators alike as they sail the choppy seas of resource allocation and health care decision-making. The beacon is a steady reminder of where the journey must end but, unlike the radar, allows the sailors (or in this example, the hospital and its constituents) to determine how they get there.

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## Endnotes

<sup>1</sup> In anthropology, Geertz applied the term 'thick-textured' to his method of using very close observation of groups of people 'to support broad assertions about the role of culture in the construction of collective life' (Kuper 1985); in philosophy, Ryle used the term to bring into view the fact that people often behave as if things had a reality beyond what might be recognised by a more desiccated view of the mind as an independent source of meaning (Honderich 1995); in ethics, Williams argues that 'Our arguments have to be grounded in a human point of view; they cannot be derived from a point of view that is no one's point of view at all' (Williams 1985).

<sup>2</sup> One of the authors (NH) was a Commissioner of the South Australian Health Commission from 1980 to 1983; the other (KMA) was Administrator of The Parks Community Health Centre (the largest of its kind in South Australia) from 1988 to 1993, then a member of the Senior Executive of the Women's and Children's Hospital from 1993. On the effort to manage a response to rationalisation in community health services, see Alexander (1994).