

People, Power and Politics in the WA Health Service

Professor Gavin Mooney

Co-Convenor WA Social Justice Network

g.mooney@westnet.com.au

Executive Summary

The key to the future of the WA health service lies with - or ought to lie with - the people of WA. It is *our* health that is involved; and it ought to be seen as *our* health service. Currently the WA health service is provider driven; it is largely the values of clinicians that determine how resources are spent. It is with the clinicians that the power over resource allocation and deployment currently lies. Since that is the case, it is not at all surprising even if worrying that the cost of the health care sector continues to escalate in what is an unsustainable way. And that is before all the extra planned beds are opened and the running costs of these fall on the system.

This paper's starting point is to argue that there needs to be a shift in power in WA health, in essence to allow the citizens of WA to have more say in setting the values or principles on which the service is to be based. Informed WA citizens have shown that they acknowledge and accept that resources for health care are limited. They then are prepared to debate what they want and what their priorities are within resource limitations. Primarily they want greater equity with special emphasis on meeting the needs of Aboriginal people but also higher priority for prevention and public health.

They also want more say in how the health service uses its resources and sets its priorities. The paper then goes on to suggest what changes are needed to meet the (resource constrained) wants of the people.

The paper argues that there are four main considerations that need to be taken into account to move current health care in WA closer to meeting both the needs and the informed, resource-constrained wants of the citizenry. First the management of the health service must reflect better the wishes of the people as citizens and tax payers. Second WA citizens want greater equity than the health service currently delivers. Third there needs to be a more rational and explicit priority setting system, reflecting a greater acknowledgment that resources are constrained and again based on the preferences of the people, and bringing more transparency to the decision making process in health care. This will lead to less provider-driven initiatives and to greater priority for community and primary care services and less of a focus on hospitals. In turn this will involve a shift in the power structure within the health care system away from clinicians to the people. And fourth there needs to be more attention given to prevention and public health.

To these ends the paper makes the following recommendations:

On Management

There needs to be greater recognition of just how difficult good management of health services is, with a suitably comprehensive search for the right sorts of people to lead the WA health service and a greater investment in training of management and leaders.

Running off to the UK NHS to learn how they do things (as has currently been proposed for senior WA health service managers) is

all very well but their system is very different. We can learn from elsewhere but the key problems and the key solutions lie here in WA. The focus of good management in the WA health service must lie in understanding the problems in our own back yard.

No amount of learning from others and training of management staff however will overcome the problems created by the current power structure in the WA health service. The power to decide on priorities needs to rest with the (informed) people of WA and not, as currently, largely with the medical profession and the AMA. We need medical expertise and medical *technical* values; we do not need medical value judgments. We do not need clinician driven management.

The existing system of areas and regions should be abandoned and management (but not values) centralised. The area system of devolved management which emerged from the HARC Report works badly and has not served anyone well, least of all the health of those living outside of Perth. There are simply not enough good managers to work that decentralised system efficiently and as a result the power ends up centrally anyway.

What do need to be decentralised are values. It is the values and preferences of people locally which should be the basis of the principles on which local health services are operated. How to turn these local values into service delivery can be decided centrally; the values cannot.

On Equity

Spending on Aboriginal health must be increased markedly not only within health care but across government.

An advisory group of Aboriginal leaders should be established to advise government on Aboriginal health. This group should be able to commission research and other work to help their cause. They would also be able to call on (and be resourced to do so) non Aboriginal people to assist them. The leadership here must be in Aboriginal hands.

A special levy should be introduced on the profits of the WA fossil fuel and mining industries to meet the extra costs of closing the gaps in Aboriginal disadvantage.

A major across-WA-universities research program needs to be established to examine the causes of inequalities in health, especially between rich and poor, and to make recommendations, direct to the Premier, on how to reduce such inequalities.

An explicit geographical resource allocation formula should be established based on 'MESH' infrastructure and 'weighted capacity to benefit' (see below) to seek to expose and then reduce the current inequities in funding between Perth and the rest of the state.

On Priority Setting and Priorities

Perhaps the greatest failing of the WA health service is a lack of explicit, transparent, rational priority setting. For too long and too often priorities have been too much influenced by shroud waving clinicians and by representatives of the AMA being quoted on the front page of *The West Australian*. A better system of priority setting in which priorities are determined more by social values is needed.

The costs of the WA health service cannot continue to be allowed to escalate. Some clear budget discipline is needed especially in the

tertiary hospitals. The state government needs to say: 'This is what we are going to spend on health care next year and no more.' They must then stick to that and ignore the squeals that will go up from the AMA and the doctors' lobby. And the government must then ensure that it is the voice of the WA people whose values are used to decide what gets cut if cuts are needed and not the doctors' lobby. Power must rest with the people through informed citizens' juries or with their democratically elected representatives.

Specifically in the spending in the tertiary hospital sector, there is a need for an analysis of the cost drivers to allow the rising costs of this sector to be first understood and then controlled.

While priorities ought to be influenced by the community's informed values, we know enough about these already to suggest that there would be a major shift in focus of health care in WA if we went down this road. There would be more money for Aboriginal health, for other disadvantaged groups and for rural and remote communities. There would be less emphasis on hospital care and more on community and primary health care and on prevention and public health. There would be more support for the mentally ill and for improving access in the widest sense.

The issue of priority setting is given great weight in this paper. Explicitness and transparency in priority setting are needed to expose the current power structure in the system which results in doctors corporately having too much say and citizens having too little say in what priorities emerge. The health service needs to be seen more as a social institution rather than as simply a medical and/or health care system.

On Public Health and Prevention

Citizens' juries in WA have consistently asked for greater priority for prevention and public health. That now needs to be delivered.

New thinking, much more aligned to the philosophy of the social determinants of health, is needed rather than the 'blame the victim' approach that so often colours the academic, research and policy debates about obesity, smoking and all the other nasty things in which the working class indulge.

More often government on behalf of the WA people need to get at the perpetrators of ill-health – those who peddle fast foods for example – and tax them or more explicitly tax their advertising budgets.

Healthy choices at a community level need to be driven by community preferences regarding what the community wants by way not only of health but also of health promotion. Often we know our sins; we need to be consulted more directly as to how we think we can overcome them – and how best or most efficiently we can become 'health virtuous'.

Power

Most fundamentally this paper calls for a shift in power in resource allocation decision making in the WA health service away from the medical profession and the AMA to the people, as WA citizens.

It is, after all, our health service.

People, power and politics in the WA Health Service

Professor Gavin Mooney

Co- Convenor WA Social Justice Network

1. Introduction

The key to the future of the WA health service lies with - or ought to lie with - the people of WA. It is *our* health that is involved; and it ought to be seen as *our* health service. Currently the WA health service is provider driven; it is largely the values of clinicians that determine how resources are spent. It is with the clinicians that the power over resource allocation and deployment currently lies. Since that is the case, it is not at all surprising even if worrying that the cost of the health care sector continues to escalate in what is an unsustainable way. And that is before all the extra planned beds are opened and the running costs of these fall on the system.

This paper's starting point is to argue that there needs to be a shift in power in WA health, in essence to allow the citizens of WA to have more say in setting the values or principles on which the service is to be based. Informed WA citizens have shown that they acknowledge and accept that resources for health care are limited. They then are prepared to debate what they want and what their

priorities are within resource limitations. Primarily they want greater equity with special emphasis on meeting the needs of Aboriginal people but also higher priority for prevention and public health. They also want more say in how the health service uses its resources and sets its priorities. The paper then goes on to suggest what changes are needed to meet the (resource constrained) wants of the people.

The paper argues that there are four main considerations that need to be taken into account to move current health care in WA closer to meeting both the needs and the informed, resource-constrained wants of the citizenry. First the management of the health service must reflect better the wishes of the people as citizens and tax payers. Second WA citizens want greater equity than the health service currently delivers. Third there needs to be a more rational and explicit priority setting system, reflecting a greater acknowledgment that resources are constrained and again based on the preferences of the people, and bringing more transparency to the decision making process in health care. This will lead to less provider-driven initiatives and to greater priority for community and primary care services and less of a focus on hospitals. In turn this will involve a shift in the power structure within the health care system away from clinicians to the people. And fourth there needs to be more attention given to prevention and public health.

2. On Management

Managing health care is difficult. Getting and retaining good managers is difficult. Good management of health care is critical.

Good managers are the scarcest resource in the WA health care system.

It is thus unfortunate that the last three Directors General of Health in WA have been drawn, at great cost in terms of the salaries they have then been paid, from within the ranks of the WA health care system and that seemingly so little effort was made to look interstate or internationally to get really good, experienced and highly trained top managers. The devolved decentralised management structure for the health service which came out of the Health Administration Reform Committee (the HARC Report) is seriously flawed. We simply do not have enough high quality managers in WA to fill all the positions adequately.

Some of the difficulties here relate to structure and some to inadequate training and experience of existing managers – plus the fact that under the regime of the previous DG a surprisingly high number of senior managers left the system and they have been difficult to replace. That is worrying. There must be the hope that, under the new DG and the new government, there will be a recognition of the need for truly high quality appointments and the promotion of a management culture that both looks after its staff and trains staff in adequate ways for the tasks that senior managers face.

As a health economist I am astonished at the lack of health economics expertise in the department. In the 21st century to seek to plan health care efficiently and equitably with little input in terms of health economics is quite remarkable!

Relevant to this is the added fact that the areas of financial and economic management were ones that the Reid Review highlighted as being in need of great improvement. The 'deficiencies' as Reid

called them on this front need to be addressed. A system of management accounting is required which will allow program budgeting to be pursued for purposes of priority setting and which reflects a program structure that is more health focused and less health service focused. (For details of program budgeting as a tool for priority setting see section 4.)

The current WA health care system still operates with clinicians on occasion filling senior management positions. The fact that this continues to be possible – and with almost no comment in the public domain of the problems that this can create - is a clear indication that insufficient recognition has been given to the need for managers to have highly relevant skills and adequate training for health service management. Senior clinicians seldom have the training to be good health service managers.

There is a need to accept that, especially given the somewhat isolated state that WA is, we will always have difficulty in attracting and retaining good health service managers. The implications of this were not recognized in the HARC Report. There is a need for a less manager-intensive structure and that means centralized management. That may be anathema to some just as the idea of having hospital boards or local or health service boards is anathema to me. The prospects for manipulation of such boards by health care professionals or local interest groups or both are very real.

In debating the question of the optimal management structure for WA health with respect to whether it be centralized or decentralized, there is often some confusion. Strictly the key issues here ought not to relate to the decentralization of management; it is decentralised *values* that are the key. We do not have enough top quality managers to run a decentralised system and for a population of two

million it does seem that to attempt to do so is in any case something of a luxury.

The reality is that while formally the system is decentralized, in practice power rests at the centre. The *appearance* that power is decentralised creates tensions and can mean that other organisations, such as the state AMA, can seek to 'pick off' locally based managers and local issues in what can become an unbalanced struggle. There is a need to strengthen the hand of management and increase their power. That is best done by accepting formally a centralized management system. Doing so will also mean that the emphasis on recognizing the need for local values will be enhanced, since the myth that local values are being used at present will be exposed. That recognition will hopefully lead to some explicit efforts to obtain these local values (of which more in section 4).

3. On Equity

The question of whose values are to count in assessments and the concept of equity is in my view central to definitions and objectives. To date most definitions of equity have come from health policy makers and have involved a 'top-down' process. WA is no exception in this respect. Yet equity is best seen through the eyes of the *potential* WA users and WA taxpayers i.e. WA citizens, in other words 'bottom-up'. If equity is endorsed in terms of access i.e. opportunity to use, it would then be necessary to look to the community for the values that are to underpin constructs of equity and access. It is the WA community who must form judgments about the extent of the hindrances or disincentives that exist to

deter them from using services and it is they who must form judgments about accessibility and how important it is to address differing heights of barriers to the use of health care.

An example of citizens judging what they mean by equity was elicited from the preferences of the WA community in a citizens' jury in Perth in 2001 (Mooney and Blackwell 2004). This exemplifies the idea of citizens' values underpinning constructs of equity and in doing so opens the door to different social groupings of citizens having a say as to their possibly different perceptions of equity.

The citizens' definition was as follows:

Equal access for equal need, where equality of access means that two or more groups face barriers of the same height and where the judgment of the heights is made by each group for their own group; where need is defined as capacity to benefit; and where nominally equal benefits may be weighted according to social preferences such that the benefits to more disadvantaged groups may have a higher weight attached to them than those to the better off.

A number of issues arise from this definition with respect to equity. The idea of the barriers and the heights of the barriers being based on the perceptions of the citizens is important in itself. If we are taking access to mean opportunity to use, it is immediately apparent that it is the potential users' perspectives of what constitute both a barrier and its height that *must* be used in assessing access and differential access. Two population groups, each facing a fee of \$50; a western style (white) health service; a male gynaecologist; and a travel distance of 100ks, will not perceive the barriers to be the same height, if one is Aboriginal, car-less, poor and culturally averse to a gynaecologist being male; and the

other white, car-owning, rich and has no problem with the fact that the gynaecologist is male.

Second these WA citizens endorsed the idea of 'capacity to benefit' rather than that of need as the extent of sickness which is the more normal basis for equity formulations and formulae. This capacity to benefit approach means that equity is driven by a concern to improve rather than a concern to address problems. The latter leaves open the possibility of equity policy leading to either ineffective policy where health care resources either do not or can not reduce some problem (for example where there is no effective treatment) or to policies where the use of health care resources may be inefficient. To adopt the capacity to benefit approach also means that judgments are required about what is meant by benefit and how best benefit can be achieved. How to achieve benefit may well involve primarily technical judgments to be made by say doctors where benefit involves health. What constitutes benefit however involves value judgments, in essence raising the *social* question of what the benefits of health care are. Again it is argued that that question is best answered by the WA community.

Certainly in considering *capacity* to benefit, it is likely to be the case that technical judgments will be needed to assess capacity. How much health improvement might result from investing in a program for increased residential care of the elderly or in increased screening of youth for HIV/AIDS? Such questions will require technical inputs from say epidemiologists and medical staff. It is to be noted however that in moving away from the idea that health is the only benefit means that other experts may be needed to assist in judging capacity to benefit. Citizens may include relief for carers as a form of benefit in the former case and reduced anxiety or increased safe sexual activity in the latter. The simple point is that,

in allowing WA citizens to judge what the forms of benefit are that they want from the WA health service, this opens the door to the inclusion of benefits which are not normally the province of epidemiologists or medical staff. Other experts such as sociologists, anthropologists and psychologists may have a role to play in assessing capacity to benefit.

The fact that different social groupings within WA may have different constructs of benefits or weight the same constructs differently would be problematical if attempts were to be made within the usual approaches to equity to deal with this issue. This is because equity is most often construed in terms of equal access *for equal need* or equal use *for equal need*, where equal need is defined as equal *health* need. If that definition were replaced by one which allowed different social groupings (for example Aboriginal and non-Aboriginal people) to define health (and hence health need) differently and to have different preferences for what they mean by benefits (and hence need more generally) then the equity construct of equal use or access *for equal need* would not be sustainable. The notion of equal need could not apply.

In this citizens' view of how best to approach equity in WA, need is replaced by capacity to benefit. This is accepted as being a subjective construct which may vary from one social grouping to another. Thus the claims to health care resources of Aboriginal people would be set in terms of (at least in part) their more holistic, community-based construct of health; non Aboriginal people in terms of primarily a western more individualistic construct of health. Aboriginal people might place more weight on involvement in decision-making on the nature of the health system. Non-Aboriginal people might weight this but to a lesser extent. Again Aboriginal people might argue that the impact of land dispossession is a basis

for a claim on health care resources. The community as a whole, Aboriginal and non-Aboriginal together, would then have to decide which of these various factors – Aboriginal health, non-Aboriginal health, involvement in decision making and the impact of land dispossession – constitute the basis of a claim and what strength (or weight) to attach to each claim for each group. That might be a difficult task but it can be done and needs to be done. Current health policy in WA gets round these issues by adopting a universal definition of equity and thereby ignoring the dilemma of different groupings' different constructs and values for equity.

To date in WA and indeed in Australia more generally, while it is recognized that Aboriginal people have very poor health status and poor access to health and other services, little has been done to establish or elicit the principles that might underlie or drive 'culturally secure' health services.

The greatest barrier for Aboriginal people in attending health services is the fact that most are in their eyes culturally alienating. Access for this cultural grouping takes on a different meaning from that of the rest of the WA society. This problem can be overcome by ensuring that services are 'culturally secure'. Houston (2004 p 15) has defined this as 'a commitment that the construct and provision of services offered by the health system will not compromise the legitimate cultural rights, views, values and expectations of Aboriginal people. It is a recognition, appreciation and response to the impact of cultural diversity on the utilisation and provision of effective clinical care, public health and health systems administration. The practical implication of cultural security is that the administrative, clinical and other service domains of the health system are systematically reviewed to ensure that their operation appropriately incorporates culture in their delivery.'

For Aboriginal people, no rational, culturally secure, health plan or strategy can be adequately pursued without establishing the Aboriginal value base for the social and cultural institution of health services that they want. Thus, critical in any Aboriginal health strategy and more specifically in the development of policies regarding equity in WA is the need to recognise two features of Aboriginal culture: the 'holism' with respect to both health and services; and the community-focus rather than individualism on which Aboriginal culture seeks to exist.

In considering an equity approach based on a bottom-up, community based, capacity to benefit set of arguments, the following questions need to be addressed:

- (i) In any WA region, what is the scope for 'doing good' with the health service resources available?
- (ii) Are the community indifferent about the relative importance of doing good to different groups who might vary by, for example, disadvantage, or might they want to weight the good to some group(s) higher than that to others?
- (iii) Where some of the difference in the scope to do good (as in (i)) is a function of the management, leadership, etc. in that area/jurisdiction, can the allocation formula 'compensate' those which are less well off with respect to this form of infrastructure?

The first point (i) is about need but uses for this the concept of 'capacity to benefit'. It does not look at the question of the size of the problem, as with the standard concept of need. Instead it is concerned with the question of improvement, i.e. doing better, in essence working with whatever concept of good is agreed by the community. It is likely that a sizeable component of the benefit in

this capacity to benefit will be perceived in terms of improved health. However, there is no reason to restrict it to that and evidence that the benefits sought by citizens from health care resources can be wider than simply health.

The second component involves a weighting factor for capacity to benefit. This reflects the idea of vertical equity, that according to social preferences, the value attached to nominally equal benefits may be different depending on who the recipients are. For example, a society might decree that people who are in poor health should have what are nominally equal benefits weighted more highly compared to those in relatively good health. Disadvantaged people would have greater claims over health care resources. In a formula for allocating resources across different peoples, this weighting would reflect the claims that such relative disadvantage bestowed on different groupings (such as in WA the poor, rural and remote populations and Aboriginal people). It is for the WA society to decide, according to their preferences, the relative weights to be attached to the different forms and degrees of disadvantage. In the country as a whole (and not restricted to WA) for example as between Aboriginal and non-Aboriginal benefits of health care, in various surveys weights of between 1.2 and 2.5 have been suggested (Mooney 2000).

Third, there is what is called "MESH infrastructure", where this refers to Management Economic Social and Human infrastructure (Mooney and Houston 2004). This concept arose in recognition of the fact that, in the original manifestation of this approach, not all Aboriginal communities were seen to be equally well placed to take full advantage of the resources allocated to them to build programs, for example in diabetic health or in eye disease. In discussion with leading figures in Aboriginal health in WA, they recognised that

some more cohesive self-governing communities function better with respect to investing in programs than do others. MESH involves the idea of social solidarity or cohesiveness with consequent good management, the availability of resources, a socially well functioning community and good human resources particularly in terms of leadership skills. Where each of these is present, there is a greater likelihood that programs on specific health problems will be able to be implemented efficiently. Where some or all of these elements are missing, then resources may well be wasted, or at best used to lesser effect.

In terms of access and equity, the key implications that flow from this approach to equity are as follows. First involving the WA Aboriginal community in planning for its health and its health services will ensure that services are then directed towards ends that are based on WA Aboriginal people's preferences, thereby being more likely both to improve accessibility and to maximise the benefit or the good (as they conceive it) from the resources available. It will ensure greater utilisation of such services than if they were imposed on the basis of "outside" values. This process of self-determination will itself help to build self-esteem among Aboriginal people, collectively and culturally, thereby leading to potentially better health and wellbeing. Thus eliciting the Aboriginal community preferences for health, health services and health service equity is the basis on which to build Aboriginal health planning and service delivery.

It is a truism that there is more to solving the problems of Aboriginal health than spending money on them. But it is just as true that without a very large increase in spending little will change. The issue is clear. Spending on Aboriginal health has to increase

markedly and this is true not only within health care but across government.

Together with Barbara Henry (Mooney and Henry 2004) I have estimated that in Primary Health Care (PHC) to deliver culturally secure health services to Aboriginal patients will cost around 50% more per patient. The overall level of PHC funding needs detailed consideration. Whatever, I recommend that such funding of PHC be based on the factors indicated in Mooney and Henry (2004), i.e. primarily, in addition to remoteness and distance costs, as discussed above, 'capacity to benefit', MESH and cultural security. The level of current funding needs to be increased by a factor of 4. While not all of that additional spend would be funded by the state, I suggest that in the short run i.e. over the next two years the WA health department's contribution to Aboriginal PHC be doubled for its health care programs. Beyond that I would propose that the state's contribution to Aboriginal PHC be 4 times the current level.

The level of Aboriginal health and the shortfall from that of non-Aboriginal Australia are not only national problems but across government problems. This is an area where the literature and research on the social determinants of health are so pertinent. Housing, transport, education, etc. are all part of the explanation for why we have failed Aboriginal people. While this is a national issue we need in WA to take a lead not least because we are such a rich state and so much of our wealth comes from the land that was originally owned by Aboriginal people. We have as a state done very well out of the minerals and gas and oil from these lands. All too little of this wealth has gone back to the Aboriginal people. That needs to change and I suggest that there be a levy on the profits of the fossil fuel and mining industries in WA to provide the money to improve the lot of Aboriginal people. We need a debate not about

whether to have such a levy but how it might be applied and at what level it might be set.

It is an important move forward that the state government has recently announced the appointment of John Sanderson to head up a group charged with recommending action to government on Aboriginal affairs. While this is commendable and an important step what it does is leave the leadership of this group in the hands of a non Aboriginal person. This is not to argue that John Sanderson and his ideas are wrong or inappropriate; merely it is to suggest that this group needs to be Aboriginal led and Aboriginal staffed but certainly with a capacity to bring others into the fold, others who are not Aboriginal but who have an expertise that may not be available in the Aboriginal community. That might mean that the eventual composition of the group in terms of the people on it would be little different. That is not the issue. At a national level and at a state level history tells us that the destiny of Aboriginal people must be based in Aboriginal hands and they must own their problems and their solutions.

There is thus a need to establish an advisory group of Aboriginal leaders to advise government. That group needs to be able to commission research and other work to help their cause. They would also be able to call on (and be resourced to do so) non Aboriginal people to assist them. The leadership however must be in Aboriginal hands.

With respect to inequalities and inequities in health and health care more generally, these exist between the rich and the poor, between metro and rural/remote, between old and young, between Aboriginal and non Aboriginal and probably between yet more groups. We currently know much less than is ideal about such inequalities and we know all too little about what to do to reduce

them. Hence this is an area where research is needed and especially WA-specific research as the levels of and nature of inequalities are likely to be different here and certainly the solutions are very likely to be different from those that might apply elsewhere in the country.

Thus a major across-WA-universities research program should be established to examine the causes of inequalities in health and to make recommendations, direct to the Premier, on how to reduce such inequalities.

4. On Priority Setting

The two biggest problems affecting the planning of WA health services are first the lack of willingness to understand and then grapple with costs. It is very difficult to get an accurate picture of what the drivers of costs are (especially in the tertiary hospitals). There also seems less willingness to grapple with rising costs than is needed. Secondly there is a failure to set priorities in a rational, informed and comprehensive way. Priority setting is about making choices based on resource limitations; not only choosing what to do but also what not to do.

On cost control I recall a CEO of a major Brisbane hospital saying that there were three key functions of a tertiary hospital CEO: budget integrity; budget integrity; and budget integrity. There is a sense in which that is a major part of the story that needs to be understood in WA. However to aid that I propose that a major analysis of the tertiary hospitals be commissioned to allow an understanding of what is driving the costs in these hospitals so that

some reasonable and relevant basis can be found to stop these costs expanding every year and risking distorting the priorities sought by the government and by the people of WA.

At the same time an analysis is needed of resources outside the hospital sector which play a part in supporting people in their own homes and keeping patients out of hospital and what more might be done to strengthen such programs. The constant calling by the AMA and clinicians more generally for more resources in tertiary hospitals and especially more beds has become a mantra. No serious attempt is made to look for efficiencies in the hospital system nor are enough efforts made to manage demand. The emphasis is almost exclusively on the supply side and then on this mantra of more beds, more beds, more beds. Whatever else, that is an expensive 'solution'. Would the same money spent in the community not be better spent? Does this question even get asked? There is a very real risk, as one ED consultant has indicated to me, that more beds simply attract more patients. This, more formally, is what is known as Roemer's Law – a built bed is a filled bed!

Planning of health care in this state must take place in an acknowledged resource-constrained environment and all the players must be convinced - if necessary forced to be convinced - that more resources will not be made available. The government needs to state: "We will spend \$X million on health care next year. That is it; there is and will be nothing more. Now as a state, what are we going to do and what will we have to leave undone?"

That then leads to the question of how to set priorities. To do so we need an initial debate to determine both the desired outcomes of health services, and the 'principles' on which decisions about these services should be made. Ideally these would be set by the West

Australian community itself. (This could be accomplished through citizens' juries – see below.)

In recent years in health policy internationally there has been increasing interest in involving communities in decision making in health care through various forms of 'deliberative democracy'. These usually involve a selection of people or a community or a meeting of citizens who are asked about certain issues.

In WA I have been involved with six Citizens' Juries (see for example Mooney and Blackwell 2004) as one form of deliberative democracy that might serve as a vehicle for the purposes of setting principles. These bring a random selection of citizens together, give them good information and a chance to quiz experts; and thereafter allow them to discuss and reflect on certain questions, against a background of resource constraints. My first hand experience with this process has been largely responsible for my being persuaded that citizens are well able to provide these values.

There are three key objectives that deliberative democracy can assist with. First there is the desire to establish which factors citizens want to be taken into account when scarce resources for health care are being allocated. These might be simply and only health or health need. They might be more concerned about addressing problems thereby focusing on health needs as sickness rather than about looking to see what difference the resources might make i.e. their capacity to benefit. They may seek resources for particular issues conditions or disease – for those suffering from mental illness, for example.

Second there are issues around equity where the citizens may seek to determine what they mean by equity, for example whether to opt for equal access for equal need or equal health and for

horizontal equity (the equal treatment of equals) or vertical equity (the unequal but equitable treatment of unequals). Weights also need to be attached to different characteristics such as for vertical equity for benefits to say poor people. The citizens or the community have to decide which characteristics of which groups of people merit having above average weights and why. Is this solely disadvantage and what in their view constitutes disadvantage - the poor, the elderly, Aboriginal people, those who are mentally ill – the definition of vulnerable would be for the citizens to decide. Which groups in this context are most disadvantaged and is this a criterion for yet greater weights to be attached to any benefits to them?

Third there may be considerations around organisational issues such as the existing balance in resource use between say prevention and cure; between the community and hospitals; and between curative and palliative care. There may also be other organisational issues which merit additional funding such as seeking to ensure efficiency and transparency in decision making; providing adequate information to the public on what services are available and when; and ensuring there are safeguards in place to promote quality of care.

To propose that the community get more involved in health service decision making is not new. WHO (1954) more than half a century ago proposed a move to have citizens' values drive health service decision making. That idea has been around since and was a major plank for example in the recent Romanow Commission in Canada (Romanow 2002).

One case study in WA involved a citizens' jury in Busselton in 2005. A group of citizens was randomly selected from the electoral roll from the South West AHS (SWAHS) here in WA. Of these, initially 30 people expressed interest in being on the jury. These

were then whittled down to 13, that process trying to ensure a good mix of age, gender and geographical location. The purpose of the jury was to allow the SWAHS to tap into the community's preferences for the set of principles they wanted to underpin SWAHS' decision making.

The jury were asked to consider themselves as being citizens of the South West – not from any specific town in the area and not bringing their own personal baggage with them. They were told that what they came up with would be used as the values foundations on which SWAHS would plan in future.

They were then presented with information by 'experts' (senior health service staff) on the health of the people in the area and relevant demographics; the services currently available; the resources available and their current deployment; safety and quality issues; and the organisational and other constraints that the health service faced. They were also given the opportunity to quiz the experts who presented the information.

Thereafter they were given time to reflect and discuss as a group what principles and values they wanted to underpin the decision making of SWAHS. Finally they came up with a list of principles. These are reproduced in the Appendix to allow the reader to understand better what might be meant by a set of principles. Clearly these are likely to vary from situation to situation.

Turning more explicitly to priority setting, there is a sense in which this is what economics is about. Economics is the science or the art of choice. Limited resources are to be allocated in such a way as to maximise benefits and at the same time ensure that health services are allocated in a way that is fair in the eyes of the society served. Given its importance and the lack of an explicit

rational priority setting system in WA, this section sets out issues surrounding priority setting in some detail.

While writing this I was aware of the frustrations I feel that economics is not accepted more in WA health in the field of priority setting. The merits of the economic approach to priority setting seem so obvious to me! Using economic analysis in an ideal fashion can be difficult, given in particular the demands on measuring techniques, especially of the benefits of health care, which are still being developed. There are also data deficiencies in all health care systems in the sense that on both the costs and the benefits side the information does not exist in the form, detail and precision that is ideally wanted.

Yet a lot of these measurement and data problems are there *whatever* methods are used to address priorities; and frequently the methods adopted are deficient. Rational priorities in health care cannot be set without knowing about the costs and benefits of different patterns of intervention. It is thus not the approach of economics to priority setting that creates these problems. They exist. In so far as other approaches sidestep these problems they cannot be genuinely useful methods of priority setting in getting us further down the road to more efficient and equitable health services.

This issue is important. Most of the criticisms that I hear of the economic approach to priority setting seem to centre largely on the practical problems of implementation. The concerns are almost exclusively with the data demands and the demands on measuring techniques that the economic approach makes.

Economics is first and foremost about a way of thinking about resource allocation. In priority setting this is especially true. The

key message of this section is that unless the thinking underlying priority setting is 'right' - and there is scope for debate about precisely what that means - then there is no possibility except by luck of getting priorities set in such a way that they will further the objectives of health care. It may well be the case in the foreseeable future that economic analysis in priority setting will not be implemented in any ideal fashion. However, an inadequate data and measuring set supporting the right thinking is more likely to get us to an approximation of where it is desirable to be than will better data and better measuring techniques where the thinking is wrong.

The essence of priority setting from an economics perspective starts from the assumption that resources are scarce. This raises two considerations. First, the concept of opportunity cost is to the fore; and second, the idea of meeting total need is simply not possible and indeed not worthy of contemplation. The starting point is therefore scarce resources.

This means getting an idea of how resources are currently being used and this is best done through program budgeting. Thereafter, the question to be addressed is how best any changes in resource use can be made, be it through some redeployment of, reductions in or increases in existing resources. This is the process normally referred to as 'marginal analysis'. It is simple and involves considering whether a shift of resources of, say, \$Z from program, project or procedure A to program, project or procedure B will result in an increase in total benefits from the resources available. If it does, then the principle lying behind the approach suggests that the movement of resources should take place. The process is then repeated until no further shift of resources is worthwhile (in the sense of leading to a gain in total net benefit). Thus the economic approach is a combination of program budgeting and marginal

analysis (PBMA) with the key concepts being opportunity cost and the margin.

Program budgeting is a simple mechanism for providing an information framework to assist the process of allowing resource use and outputs generated to be set alongside health service objectives and for helping to identify and begin the examination of relevant margins through marginal analysis. Program budgeting is not evaluative in itself, but rather creates a framework in which evaluation is facilitated and encouraged.

In WA it is possible to identify a series of broad programs, for example, by disease group - cancer, respiratory disease, etc.; by client group - the elderly, mentally ill, etc.; or perhaps by geographical location. There is a range of possibilities. However the distinguishing feature of programs is that they are 'output' orientated rather than 'input' orientated, as is the case with standard budgetary procedures. This is because, while the total spending on nurses (an input), for example, is an important piece of information in managing health services, the role of program budgeting is to allow planning of health care and priority setting across different aspects of health care in ways that relate to the objectives of health care. It is this 'objectives' orientation that requires program budgeting to be output orientated. More simply, it might be said that the designation of programs ought to be such that all programs can have health care objectives associated with them, which is clearly the case for maternity care or cancer therapy. It is this output and objectives orientation that distinguishes program budgeting from other forms of budgeting.

While there are various ways in which these tasks might be accomplished, it is important to establish a program group or program management group for each of the programs. These might

comprise professional staff working with the patients in the program group - doctors, nurses, etc., managers for the program, information and finance staff, and perhaps lay representatives. How such groups are set up will again depend on the local circumstances, but some grouping into 'program management groups' will certainly be needed to get the process working in practice.

These groups have the task of taking the principles established by the citizens' juries and putting them into practice by way of setting priorities for resource allocation.

Three questions can be asked.

1. If there are no more resources available, can, say, \$1million be moved from program X to program Y and the overall total benefit be increased?

2. If more resources are made available, on which program or sub-program are these additional resources best spent in the sense of creating most extra benefit?

3. If expenditures are to be cut, where should the cut occur so that the impact in terms of loss of benefit is minimised?

Steve Jan has exposed a number of problems in getting acceptance of economic analysis in health care and in particular of priority setting. He identifies as a major issue the lack of 'credible commitment' (Jan 2003), specifically in the application of PBMA. He states: 'when individual managers have reason to doubt the veracity of submissions provided by other managers, the potential exists for such exercises to break down. In this institutional environment, each program manager is unable to commit credibly to providing an accurate evaluation. This situation results from the conflict between individual objectives of each manager to maximise his/her budget

and the expectation that each manager will promote broader organisational objectives by providing, in good faith, information that might then be used to cut his/her budget' (p 272).

One way of overcoming these problems is to bring in the WA community who do have an interest in organisational efficiency and who are potentially present for the long term. They have an interest in efficiency not only of the organisation (for which they are paying through taxes) but also of the way in which resources then get allocated. They can also, should they see fit to endorse the principle, be the judge of what form of equity they wish to see pursued and what relative weight they wish attached to it vis-a-vis efficiency. They can thus set the principles or constitution as discussed above. This separates the question of the setting of values/principles from the roles of decision makers within the WA health service, thereby reducing for these decision makers the barriers to commit credibly to both the goals of the service and the process of priority setting.

Thus bringing in the WA community and their values gives these actors influence over decision making which will decrease the problems of lack of credible commitment and in turn strengthen the desire to promote efficiency and equity as health service principles for priority setting.

5. Prevention and Public Health

Citizens' juries in WA have consistently asked for greater priority for prevention and public health. That is so often the rhetoric of health care systems and not just in WA but in practice it just does not happen. There is a myth about that given the choice between

more hospital beds and more prevention the public will opt for the former. It is a myth and it is one that too often is perpetrated by medical doctors and the AMA who have the power and the vested interest to want more and more acute beds built. The evidence that this is what the informed public want is just not there. The results of the WA citizens' juries indicate clearly that given the choice between more prevention and public health or more acute beds, they have never yet opted for more beds.

Given the power structure in WA health care at present, the voice of the public calling for more prevention is not heard. It is the power of the AMA and the medical profession more generally that results in more and more money going into the acute hospital sector and especially the tertiary hospitals. Policies around the management of demand are largely ignored and those on the management of supply are reduced to the issue of more beds. More beds has become an AMA mantra. There needs to be shift in power to the informed people to alter this focus and to shift the balance between health care, particularly acute hospital care, and prevention.

There is however also a problem within public health as a discipline in WA with too little thought being given to the structural social and economic issues that are so central to the theories underpinning the social determinants of health. Too often in prevention and public health the sufferers are seen as being at fault with policies then built on a philosophy of blaming the victim. Why do so many Aboriginal women smoke? Well maybe they have a rather grim life and that is a way of partial escape. Why do many Aboriginal men drink and end up violent? Well without in any sense seeking to excuse their behaviour, maybe we need to look at the reasons and, in addition to any anti-smoking and anti-drinking

campaigns, look a bit deeper at the underlying causes. Blaming the poor 'SODs' – Smoking Obese Drinkers – is not the solution and the fact that these problems are more prominent in the poor and disadvantaged in the population must tell us something about the reasons behind this behaviour.

New thinking, much more aligned to the philosophy of the social determinants of health, is needed rather than the 'blame the victim' approach that so often colours the academic, research and policy debate about obesity, smoking and all the other nasty things in which the working class indulge.

There are those who make a profit out of cigarettes, alcohol and fast foods. That is legal as things stand. There is however a strong argument for trying to get the perpetrators who supply these products on the market to change their ways. There is nothing that says that the market will provide health; the market is about profit maximisation not about health and certainly not about health maximisation. If we want to get healthier products on the market, we need to interfere with the market. That can be done by trying to alter the behaviour of the consumers or trying to alter the behaviour of the suppliers. Why the monopoly of interest of public health gurus on consumers' behaviour?

More often we need to get at the perpetrators – those who peddle fast foods for example – and tax them or more explicitly tax their advertising budgets. In WA we could for example place additional taxes on fast food companies or, yet more targeted, on their advertising and marketing budgets. Such a tax might be 100% of the marketing budget for the worst contributors to obesity-inducing foods but with a tax gradient for the lesser contributors, based on some obesity-inducing index. This would encourage suppliers to produce lower obesity inducing foodstuffs, thereby lowering their

taxes. At the same time, since inevitably some of the tax would be passed on to consumers, it would encourage less obesity-inducing eating habits in the population at large.

Currently too the population at large is not consulted with respect to what they want by way of better health – do they see obesity as a bigger problem than smoking? Do they want more money spent on smoking reduction or on reducing excess alcohol consumption? Nor are they consulted about what they want by way of health promotion at a community level. Clearly there would need to be some sort of educating of the community (or use of citizens' juries) on such matters but the preferences of the community can be obtained and used in a way that reflects both their community values and experts' advice.

Thus healthy choices at a community level need to be driven by community preferences regarding what the WA community wants by way not only of health but also of health promotion. Often as WA citizens we know our sins; we need to be consulted more directly as to how we think we can overcome them – and become more 'health virtuous'.

6. Conclusion

The key conclusion to this paper is simple. Health care resource allocation, its efficiency and equity are inevitably based on the power structure of the WA health service organisation. As the WA health service is currently construed, I have argued that too much power on resource allocation decision making and on priority setting rests with the medical profession and the AMA. We clearly need

doctors at the sharp end of health care and in WA I am clear we have some truly excellent dedicated doctors – and other health care professionals. We also need doctors’ technical expertise in helping to judge what the effectiveness would be of more resources in screening for breast cancer or of spending more on Aboriginal diabetes or of allocating more resources for palliative care. Faced with choices *between* these however, then value judgments are needed. A key point of my argument is that these need to be social value judgments. They are not medical technical judgments. It is about these issues that we need to hear the voice of the WA citizens. We as citizens need to have more say in what our health care system as a social institution is to do for us, the WA community. It is, after all, *our* health service!

References

Health Administrative Review Committee (2001) Report. Perth: Department of Health

Houston S (2004) The past, the present, the future of Aboriginal health policy. PhD Thesis. Perth: Curtin University.

Jan S (2003) A perspective on the analysis of credible commitment and myopia in health sector decision making. *Health Policy* 63 3 269-278.

Mooney G (2000) Vertical equity and health care resource allocation. *Health Care Analysis* 8 3 203-215.

Mooney G and Blackwell S (2004) Whose health service is it anyway? *Medical Journal of Australia* 180 76-78.

Mooney G and Henry B (2004) Funding Aboriginal health care. *Australian Journal of Primary Health* 10,3.

Mooney G and Houston S (2004) An alternative approach to resource allocation: weighted capacity to benefit plus MESH infrastructure. *Applied Health Economics and Health Policy* 3 1 29-33.

Reid Review (2004) A healthy future for Western Australians. Perth: Department of Health.

Romanow R J (2002) Building on Values: The Future of Healthcare in Canada <http://www.hc-sc.gc.ca/english/care/romanow/hcc0086.html> Accessed 21 November 2008.

WHO (1954) World Health Organization (1954) Report of the Expert Committee on the Health Education of the Public. Technical Report Series 89. Geneva: WHO.

Appendix

An example of a citizens' jury's set of principles (South West Area Health Service)

Fairness

The principle on which the citizens placed most weight was fairness (equity).

They defined this as equal access for equal need, where equal access involved equal opportunity to use health services. The barriers to using health services were many, including financial cost, distance, racism, etc. Equal access was where people perceived the barriers they faced to be equally high; need was taken to be capacity to benefit (i.e. how much good can be done?) and disadvantaged people were to be weighted more highly (e.g. higher weighted health gains for Aboriginal people).

In general they had a particular concern for the most disadvantaged, especially the health of Aboriginal people.

At the same time the jury acknowledged the "trade-off" or competition between equity and efficiency.

Efficiency

Efficiency was seen by the jury in two ways: first in terms of doing things as well but more cheaply or doing more with the same

resources; and second it is about doing as much good as possible (benefit maximisation) with the resources available.

The citizens were of a view that the second type of efficiency needed more emphasis i.e. there should be more consideration given to priority setting across different programs. For example should the health service spend more on maternity care even if that meant less on care of the elderly?

With one notable exception they were not inclined to argue for higher priorities/ increased spending for certain specific areas. They did want to ensure that such priority setting was done explicitly. The exception was services for the mentally ill.

Where they wanted to make savings, if these had to be made, was through hospital rationalisation. They believed that the existing deployment of resources to and in hospitals and Emergency Departments was inefficient and asked that SWAHS examine ways to rationalise these. They suggested for example that some of the hospital buildings might be converted into aged care facilities or to provide services for the mentally ill.

Trust with respect to safety

A third set of principles related to quality, safety and risk management. In this context their strategy was one of trust. They trusted SWAHS to 'take care of' these issues on behalf of the community.

Prevention

The next principle was prevention. They wanted a higher priority for prevention but were concerned with 'value added'. By this they meant that, where other organisations (e.g. the Cancer Council, Heart Foundation) were already involved in prevention, SWAHS

should avoid duplication and concentrate on prevention that would not otherwise be pursued.

In discussing health promotion within the context of prevention they saw the objective as being about promoting informed choices about health issues.

Self-sufficiency

The area was such that some patients went to Perth. On the principle of whether SWAHS should aim for greater self-sufficiency in treating patients, the jury had no strong views but felt that total self-sufficiency did not make sense. The extent of self-sufficiency must and should vary by condition.

Holistic care

The jury expressed concerns about 'body parts' medicine and saw an increasing role for holistic health.

Transparency and accountability

The citizens supported transparency in decision making in SWAHS as exhibited in the holding of the citizens' jury.

Community values

Finally they endorsed the principle of the community establishing the principles and values on which SWAHS should base its decision making.