National Consultative Ethics Committee for Health and Life Sciences

Opinion N° 101

Health, ethics and money: ethical issues as a result of budgetary constraints on public health expenditure in hospitals

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Introduction

Health care expenditure never ceases to escalate, financial difficulties in hospitals and reforms continue to accumulate and the concern of decision makers remains unabated. In this context, Madame VAN LERBERGHE, at the time General Director, *Assistance Publique-Hopitaux de Paris*, asked CCNE to give an opinion on the ethical problems raised by budgetary constraints in hospitals, in particular as regards decisions on exceptionally costly treatment or surgery. What criteria should be used to arrive at an equitable decision when a choice has to be made between two frequently contradictory imperatives: preserving the health of an individual versus the responsible management of a community's health care? Should the underlying logic be based on mutual interdependence and solidarity as regards health or should public funds be allocated as best they can on the basis of a common property on which everyone has a claim?

Since the economic legitimacy of these activities is the improvement of public health, it must necessarily refer to ethical principles, as Amartya Sen postulated, reintegrating economics as a moral science. Such a constraint implies that macroeconomic indicators cannot be defined independently of the cultural, psychological and ethical context of their sphere of application. The fact that the ever present budgetary constraints tend to obscure the ethical dimension of the range of choices open to hospital decision makes this interdependence all the more necessary.

In the last twenty years or so, the relationship between patients and doctors has moreover become increasingly concerned with judicial considerations. As a result, the decision-making process may be modified by the knowledge that courts could recognise the existence of physician liability although no medical fault in the true sense of word has been committed.

Medical progress today is inseparable from soaring financial investment and commitment in every department of medicine, so that *health care management* has become essential, together with constraints designed to make the cost of medical protection acceptable. It also encourages new attitudes; the *moral contract* between doctors and patients is no longer based entirely on an *obligation of means or due care*. There is a move in the direction of an *obligation to achieve results,* which is of necessity more costly and must lead to *rationalisation of expenditure* to avoid what in effect would be *rationing of care.*

This potentially stressful situation (health comes at a cost and cost leads to constraints) can endanger the very principles of social protection. Disregarding the finite nature of available resources would necessarily lead to restricting access to health care. For some patient populations access would then be a question of chance or discrimination, with major ethical consequences.

The need for equity signifies that choices must be made. They should be deliberate rather than forced, be they made in fact by patients, their families, hospitals or the authorities. The same ethical concerns connected to collective issues were previously the subject of CCNE's Opinion n° 57[1], which warned against the two major risks arising out of authoritarian limitations on financial resources: loss of accountability on the part of social actors and impaired access to care (increased waiting times, exclusion, rejection, etc.). which primarily

[1] Opinion n° 57 "Technical Progress, Health and Societal Models: The Ethical Dimension of collective choices".

affect the most vulnerable. Decisions must reflect recognised priorities so that they are not dictated by the arbitrary effect of unsuitable indicators.

CCNE recognises as a matter of course that some prioritisation is unavoidable to take account of the State's budgetary constraints, but emphasises that such choices are a matter for *debate by society*, that they integrate a *political dimension* and that responsibility for making them cannot be left solely in the hands of hospital actors who are inclined to divergent aspirations.

The fundamental principles and the ethical issues arising out of economic and budgetary constraints in hospitals must be the subject of thorough discussion by the entire community and policy makers to evaluate the *scope and the consequences* of the various *possible strategies* that could be adopted to improve the cost/effectiveness ratio of the hospital system, with *due regard for the missions assigned to that system*.

A *balance in pure accounting terms, taking only into consideration the liabilities* (the cost of services) without *relating them to the assets* which are their counterpart (the benefits for the community or those that can reasonably be expected from the adoption of a new system of calculation) would not be acceptable. Nor can the overall effects be disregarded, including possible adverse effects which could occur if one or other criterion gave excessive weight to a single system of accounting measurement which is supposed to lead to more effective control of hospital costs[2]. Failing to recognise this danger could lead the French public health system, of a hitherto indisputable and recognised quality, into major financial difficulties.

CCNE clearly does not wish to present an excessively angelic vision of the budgetary constraints problem. On the contrary, the Committee is making the point that ethics and economics are not incompatible. It is both necessary and entirely feasible to discuss economics on an ethical basis, as a recent report by economic actors reminds us[3].

1. Principles governing the evaluation of the cost of hospitalisation

A precise definition of the objectives of the hospital healthcare system must be the basis for any policy designed to achieve better control of costs. These objectives are in particular :

- to treat any condition that cannot be managed in the patient's home, irrespective of the degree of severity of that condition (so that logically, alternatives to hospitalisation such as ambulatory surgery and more palliative care at home should be developed);
- to help reduce inequality of access to the health care system due to geographic location, age, social and professional category or extremely precarious living conditions;

[2] The authors of a recent study published by the International Monetary Fund ("What macroeconomists should know about Health Care Policy") also point out that the cost of health care cannot be dealt with in purely accounting terms. They add that market logic is not an appropriate yardstick because of the risk of inflation due to asymmetry between the offer of health care and patient expectations, which requires State arbitration (see also "*Une approche comptable qui pénalise l'accès aux soins», in* «Le Monde-Economie», June 13, 2007.

[3] The aim is "to report on good practices... which manage to reconcile good management and profitability criteria with principles of equity and solidarity". (Antoine Meyrieux, *Rapport moral sur l'argent dans le monde*, (Moral report on global money) 13th edition, 2007)

- to contribute effectively to patient re-insertion into society after hospitalisation;
- to promote better health care through a deliberate quality improvement policy.

The mission of hospitals

Over and above its traditional and fundamental mission of care and attention to patients, which includes medical management, teaching, research and therapeutic innovation, hospitals are invested with a duty of social assistance and aid. Although not its most visible attribute, this assistance is essential to preserve the *social bond within society*, beyond the obligation of *constant availability of care,* since hospitals are practically the only public service open night and day. According to the World Health Organization (WHO), an equitable public health policy must not only fight disease, but must also provide the population with a minimum of well being and contentment. In fact our country presents a paradox: its inhabitants enjoy one of the world's longest life expectancies co-existing with marked inequalities in terms of health. For the most vulnerable of its citizens, life expectancy in France is similar to certain countries of the third world[4]. If the social mission of hospitals came to be neglected, the risk of aggravating these social and economic disparities would increase. These considerations underline the essential role of hospitals in promoting national solidarity and the scope of social welfare activity; the corresponding constraints must be identified and measured independently.

There are also significant inequalities as regards morbidity in France: the incidence of tuberculosis is one hundred times greater for those who are culturally, socially and economically underprivileged. The life expectancy of the homeless is closer to African norms than to the French average. Medical management for the underprivileged is far from ideal: those suffering from psychological disorders and the elderly, for example, do not always benefit from adequate counselling[5]:

- The seriously underprivileged combine the disadvantages of maximum exposure to risk and limited access to health care. They are more exposed than others to pathologies connected to the environment and deviant behaviours (such as increased prevalence of pathologies linked to tobacco and alcohol abuse) for which medical management is less readily organised than for more socially acceptable conditions. The very limited reimbursement by the national health system for dental, auditory and optical medicine has, for a very long time, been the expression of a less generous public health policy for the poor, as though such care was provided for convenience or to satisfy an appetite for luxury.

- A person's age is often the justification for delaying a medical procedure or foregoing resuscitation. In itself, age is far too simplistic a notion to serve as a selection criterion. A large number of scientific publications point to the fact that age alone is not an independent factor for an unfavourable diagnosis; on the contrary, rapid action to maintain autonomy and mobility in frail and aged patients can produce significant health improvement[6].

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[4] "Manifeste contre la pauvreté" by Martin Hirsch and Jérôme Cordelier, Oh Editions, 2004, 180 p

[5] The paradox residing in the fact that only the elderly pay personally for their hospitalisation, when a "prolonged stay" *(classified as "long séjour")* in hospital is involved!

[6] Paradoxically, hip replacement for patients in their nineties can provide several added years of life expectancy and therefore be a saving by preserving some degree of autonomy, whereas on the contrary, loss of mobility can lead to costly loss of autonomy.

The consequences of veiled discrimination are particularly serious when the mission of providing care for the population as a whole is involved. For example, an identical length of stay in a pædiatric ward or an accident and emergency department is not weighed on the same scale in a hospital in a prosperous neighbourhood or one in an underprivileged area. Selection in such cases is an agonising choice.

Undoubtedly in such cases there is inequality of access to care and we cannot dispense with an assessment of the situation: the consequences of not choosing are of always tipping the balance of the allocation of health care to the detriment of the most vulnerable. This is exactly the kind of development that we must fear in the present circumstances; it is evidence of the unethical nature of not choosing.

Inequalities, ethical dimensions and "profitability"

We have already referred to the ethical dimensions of reflection on the inequality of access to health care. But what does "justice" mean in terms of patient treatment? Is it right to limit health care for someone because the cost of medical management seems too high in comparison with available resources? Should, if necessary, the principle of universal equality in the face of sickness be swept aside so as to achieve a more equitable distribution of health resources and services?

Generally, two opposite types of response to this questions are given: an "equalitarian" (so-called "deontological") versus a response described as "utilitarian""[7], or "distributive justice". Current developments in society, reinforced by the crisis in health care expenses, are increasingly inclined to favour the "utilitarian" concept to the detriment of the equalitarian ideal ("to each according to his needs".).

After the ruinous Second World War, international law codified this concept of justice, making dignity consubstantial with the person[8]**.** The current context for public health expenditure would seem however to force us into qualifying these person-focused ethics. In the last few decades, although respect for dignity is still central to ethical thinking, there is noticeably increasing emphasis on the quality of people's lives, giving more importance to *equity* compared to *equality*, when the two values cannot be reconciled because there cannot be unconditional compliance. From that perspective, although human health is beyond *price*, it does have a "*cost"*.

[7] In the "egalitarian" perspective (inspired by E. Kant), a just action is one which respects human dignity. The concept of "dignity" designates an unconditional value, unlike the notion of "price" which is a relative value to be attributed to the use of an item or the usefulness of a service. In this egalitarian concept of justice (which article 2 of the French code of Medical Ethics emphasises), everyone must be cared for according to his needs, regardless of circumstances, age, hierarchical grading and degree of social value. Unrelated to physical appearance, mental and somatic health, dignity is held to be a moral benefit requiring a duty of unconditional hospitality. Utilitarianism, on the other hand, upholds the need for a rational distribution of health care as a function of the collective needs of the community. From this point of view, to be just is to be equitable. Consequently, the duty of justice does not necessarily coincide with investing considerable sums of money on an excessively small number of cases.

[8] It is significant that the very first line of the Preamble of the UNIVERSAL Declaration of Human Rights of December 10, 1948 refers to the: ..."recognition of the inherent dignity ...of all members of the human family".

It is therefore understandable that utilitarianism, the moral doctrine based on utility or "the greatest happiness principle"[9], does have an influence on criteria for health care decisions. In a limited resources context, it could lead to tragic decisions in some cases (such as ceasing to reimburse costly medical management over a certain age limit, or the decision to invest in the treatment of frequent diseases to the detriment of rarer conditions, etc.).

Disagreement between these two schools of thought and the growing influence of the utilitarian philosophy in our current society raise a question: have we arrived at a point in our history where a doctor is no longer allowed to consider his patient's human dimension? It is true that a utilitarian attitude can help to highlight the contradictory interests that pervade society. Nonetheless, the utilitarian principle of the "greatest happiness of the greatest number" cannot meet the demands of justice if it is achieved at the expense of the greatest unhappiness for a small number. In practice, existing tension between person-centred ethics and utilitarian ethics leads to choosing between two contradictory demands: on the one hand achieving effectiveness in a competitive environment, on the other accepting a public service mission assigned specifically to hospitals by the code of public health. The ethical and economic constraints of the hospital system — which is also true for the more general context of democracy — in fact reside in the opposition between two apparently mutually exclusive concepts: the "unconditional value" of an individual and "satisfying the greatest number".

In view of the ethical dimension of its mission, can and should hospital management strive for both equity and profitability? For that matter, what can profitability mean applied to a hospital? It cannot be evaluated in the same way as for a commercial company where cost is balanced by income derived from the sale of goods or services. The clients of a company can afford to pay the actual cost of their purchase and are free to decide whether they want to buy or not; this is obviously not the case of people in need of hospital care. For that matter, would it be ethical to prefer health care which "earns" a profit, i.e. the real cost of which is less than the income generated by its selling price? Private non-profit making hospitals, often held up as a management model, rarely make substantial profits.

Hospitals do not actually market their services; some of these, such as the preservation of a nation's health capital, are of great added value for society but cannot be calculated in terms of income. From that point of view, it is important not to consider a hospital's added value over too short a period of time and so ignore the time scale required to appreciate its impact on the preservation of human dignity.

Some diseases may require the use of costly and prolonged treatment for a single individual; but how is equity to be satisfied if the selection of that person is based on implicit criteria and is to the detriment of access to care by other patients? The example of availability of treatment for AIDS when it was first introduced is interesting in this context. Faced with a massive imbalance between the pharmaceutical companies' limited production capacity and the large number of patients for whom such drugs were indicated, in 1996 patient support groups suggested solving the problem by drawing lots. Despite the harshness of such a method, they considered it to be less inhumane, and therefore less unethical, than basing the decision on consideration of the stage of the disease or the severity of its consequences on patients. Awareness of this situation led to giving it further thought which helped to exercise pressure on the authorities, so that a paradoxical outcome was an increase in the number of beneficiaries of the new forms of treatment.

[9] Mill J-S., *Utilitarianism* (French translation. G. Tanesse), Flammarion « Champs », Paris, [1861], 1988, p. 48.

Selection criteria, acceptable to both society and patients, must therefore be defined, and they cannot be based on the sole "profitability" factor. Preservation of the common good, that is "public health", cannot be entered into the equation in the same way as an ordinary "product": it is also the cornerstone of a public service which maintains an essential link with citizens. For society, the value of such a link is beyond price. Nor is that cost for such a fundamental function as exorbitant as is sometimes assumed.

2. On the necessary consideration of the problem as a whole

Including benefits, and not only costs, in the hospital balance sheet

The *cost of hospitals* and of health in general must therefore be assessed with due regard for the benefits they provide to the population as a whole, even though these are difficult to evaluate in accounting terms. The evaluation of a health care system should, for example, take account of the cost incurred, *a contrario*, by the absence or the partial discontinuation of a strategy based on effective health care for everyone. The "loss of earnings" brought about by this situation (increased morbidity, mortality and disablement, loss of active workforce, greater degree of dependence, etc.) could possibly be quantified, at least approximately. Attempts at costing the "loss of earnings" for a country deprived of elementary health care systems suggest that the real cost of a health policy as a proportion of the country's gross domestic product could be reduced to a much more acceptable figure if the expenditure that society would have to make in the absence of such a policy was deducted from the equation.

Similarly, it is worth remembering that health care expenditure also represents investment which has in itself a positive impact on economic activity (this is not profitability in the financial sense of the word): the construction of hospital buildings and the production of medical equipment and of medicines make a positive contribution to growth and create employment opportunities. A global examination of hospital activities should compare the costs they generate to the entire array of direct and indirect benefits they produce.

Finally, hospitals are only one of the kinds of structures coping with health related problems. They do not have a monopoly. It would be a mistake to give the impression that hospitals, on their own, can solve every problem raised by disease. This is certainly not the case. Hospitals are a link in the chain, a primary and essential link no doubt, between all that comes before, i.e. the network of general practitioners, community health centres, etc. and all that comes after, i.e. rest and convalescence homes, spas, hospitalisation at home and also various other institutions providing assistance, some of them being charities. Hospitals alone are never able to cope entirely with the full social and economic dimension of ill health; they can only contribute to solving the problem.

So that the health care system as a whole is not endangered by cost saving strategies, these strategies must be evaluated, not just for their financial impact, but also as regards their global impact on the quality of care and the state of health of the population concerned. Whereas arguments such as social position, professional environment and prior links of the patient to the hospital, are sometimes put forward to select certain patients, on the contrary, age and precarious circumstances are all too often a cause for discrimination. Age as an isolated criterion is far too simplistic a factor to serve usefully for selection.

The incidence of innovation

Scientific innovation may have ambiguous financial effects. It can reduce the length of hospital stays, improve the quality of life and so generate savings. The increase in cost following on medical progress is the obvious counterpart of these positive impacts. New and effective treatment may be extremely costly. For example, the use of anti-TNF[10] antibodies improves the status of a great number of patients suffering from rheumatoid arthritis; VEGF[11] antagonists can be of significant therapeutic benefit to halt age-related macular degeneration; protein substitution therapy (indicated for a number of hereditary enzymatic deficiencies) is even more expensive and of benefit only to a restricted number of patients. Nevertheless, efforts to offer the best possible treatment should not lead to using, except as part of therapeutic trials, recent and costly treatment of unproven efficacy.

A number of new examination techniques have improved the quality of diagnosis, but also its cost. Radiology for example has evolved along with technological progress, with the adoption of new methods such as ultrasound, CT scans, nuclear magnetic resonance and positron emission tomography (PetScan). Their use by physicians can lead to a "battery" of medical tests which are not necessarily part of a rational complementarity strategy. The race to arrive at the most perfect diagnosis can push patients and doctors into scheduling additional but pointless tests, sometimes to bolster the urge — albeit illusory — for maximum security, sometimes even to "prove" *a contrario* that the patient is in good health.

To arrive at a more considerate and respectful practice of medicine, this trend for "technology overkill" must be challenged. Better knowledge of what is needed and more accurate evaluation are essential to rein in the tendency for an excessive share of hospital resources being used to finance a technology and drug race which can never be of benefit to a majority of people since the cost is too high for general use and the system is skewed in favour of those who are already privileged. Those who are most vulnerable, who are less aware of technical possibilities, are less inclined to demand more technology. The paradox is that gratuitousness is of more benefit to people who are better off. Necessary collective reflection on this subject should help to redefine the missions of major hospitals so that innovation does not focus exclusively on the biological aspects of medicine to the detriment of its other dimensions.

The pertinence of therapeutic action must be improved by reducing to a minimum the disproportion between effectiveness and the scale of resources that are put to use. Although there are obvious cases of wastefulness, it cannot be denied that certain costly therapies are also effective and useful. In some cases, an initial outlay can generate substantial savings if the cost/benefit evaluation is holistic, and the various medical departments are not considered separately, which is also helps to improve the overall quality of medical practices. It has been demonstrated that effective pain management after certain kinds of orthopædic surgery can, for a modest increase in initial expenditure, improve the long term functional prognosis and reduce the need for secondary "consumption" of medicines and physiotherapy.

However, if the health care on offer fails to match the new therapeutic possibilities they are unlikely to be effective. The scarcity of up-to-date specialised facilities for treating strokes and of MRI for their diagnosis in France (compared to other European countries) means that a large number of patients become lose their autonomy and are a heavy burden on

[10] Tumor Necrosis Factor

[11] Vascular Endothelial Growth Factor

the national sickness insurance scheme. On another front, the inadequate development of outpatient surgery and health care at home in France compared to other European countries is a good illustration of French reluctance to accept these adjustments, although the medical pertinence of ambulatory care and the savings in human and financial resources they bring about, are very obvious.

Hospitals should therefore learn how to make more balanced and rational use of expenditure for innovation. The more economical forms of medical management should be preferred. An evaluation of the cost/benefit ratio must become as important for practitioners as the benefit/risk ratio[12].

Medicines

The cost of hospital drugs in a monopolistic situation is anything but transparent. Pharmaceutical companies are frequently able to dictate a price to a commission which can of course protest but is generally obliged to bow to the financial demands of the company. Payers have to pay out. It is true that the infrequent occurrence of a disease, and therefore the infrequent therapeutic use of a suitable drug, can justify a company's demands for an adequate return on investment. The law of the market always prevails. However, payers could be in a much better bargaining position in view of the fact that they hold a monopoly on demand.

In a reverse process, a drug which is expensive when sold in pharmacies on private sector prescription is often sold at rock-bottom prices to hospitals to encourage later prescription by GPs. This negative dumping process appears to be beneficial for hospital finances but in fact places an extra burden on the sickness insurance system which, outside hospitals, is reimbursing more expensive drugs.

Finally, it is strange that the same institution sometimes encourages the filing of patents for which they are simultaneously paying out royalties and receiving patent rights. It would be worth encouraging studies of the benefit/expenditure ratio. Although it does not seem illogical that the research units of AP-HP (*Assistance Publique - Hopitaux de Paris*) and other major institutions should earn royalties from departments using their patents, a critical analysis of the cost/benefit ratio for such royalties would be advisable.

Prevention and precaution

The 19th century was dedicated to prognosis and prediction, thanks to scientific progress and its technological applications, and the 20th century was characterised by prevention. The 21st century will be committed to precaution, but faulty implementation of that principle can lead to excessive legalism. The increasing frequency of lawsuits involving legal liability for physicians, either for negligence or insufficient regard for the precautionary principle, also contributes to an increase in expenditure intended for limiting the exposure of hospital healthcarers and/or the hospital to the risk of legal proceedings more than for treating patients.

It is therefore important for the practice of medicine today in France that the precautionary principle should be kept in its proper place — that of *pragmatic prudence* in conclusion of a critical case by case examination — and more attention and resources devoted

[12] Cf for example: B. Grenier : "Justifier les décisions médicales et maîtriser les coûts", 4th édition, 2006, Masson, Paris, 141 pages. (Justifying medical decisions and cost control).

to prevention, which is sadly lagging behind in this country. A global evaluation of our health care policies cannot but highlight the contradiction between the meticulous scrutiny presiding over early detection of all identifiable genetic disorders and the shortcomings of relevant prevention and counselling practices, although logically, the only justification for detection would be such follow-up, for example pædiatric monitoring[13]. Prevention, technical progress and follow-up can never therefore be evaluated separately and should be financed in proportion to resources set aside for innovation as a demonstration of the complementarity between economic and ethical rationales.

Much more energy should be devoted to raising public awareness on the responsibility of individuals to take effective measures to protect their own health, and also to change mind-sets so that the need, and advantage, for a more level-headed form of medicine, one more capable of constant self- reassessment, becomes apparent.

3. *On the dangers of a single instrument for measuring the cost/benefit ratio*

No single evaluation method is either entirely objective or universally applicable. It is both illusory and dangerous to try and validate an evaluation method on the basis of so-called "norms" which are generally no more than arbitrary concepts or self-validating criteria.

Each of the numerous economic indicators used to evaluate the efficacy of hospital systems has its own specific advantages, defects and comes with its own set of potential perverse effects, preferring certain objectives while others are ignored. In practice it would therefore be advisable to use evaluation instruments suited to each category of objectives. Furthermore, such instruments can only be effective in certain conditions: concrete objectives must be defined beforehand and generally acceptable to all concerned, they must be weighted and ranked in explicit and transparent terms, they must be provided with repeatable and objective indicators and specific resources must be allocated to them. Constant efforts will need to be devoted to follow-up and, should the case arise, to correcting the discrepancy between expected objectives and actual results.

Multiple choice criteria

The criteria providing insight on the pertinence of budgetary decisions in hospitals vary considerably, but each and almost all of them tend to privilege the interests of a *single category* of those who have a stake in the public health system (members of the medical profession, nursing staff, patients or hospital managers, etc.); the criteria cannot therefore be considered separately. The problem raised by the diversity of criteria is compounded by the degree of "lobbying" capacity or of the power to influence decisions in each case. Most of the criteria are supported by powerful forces. All too often, support is lacking mainly for the vulnerable and those whose status is precarious.

The following are some of the more salient and frequently selected criteria:

- *medical,* aiming primarily to benefit patients by increasing their life expectancy and quality by the use of methods acquired through scientific and medical progress. This obligations of means or due care must involve critical review on, in particular, the

[13] The decision to organise screening or early diagnosis procedures can only be justified by the inevitable further decision to organise medical management of the anomalies revealed by these procedures. But this is, alas, not always what in fact happens.

issue of the *urgency* (real or otherwise) of their use, on the existence of *other possibilities* and on the appropriate use of the *medicines* prescribed as regards their certification status. There should also be an *a posteriori* evaluation of results.

- *innovative*. Innovation plays an essential role, not just from the point of view of technical progress and the development of new therapeutic approaches, but also to improve the efficacy of patient monitoring methods. However, innovation should not lead to an accumulation of redundant procedures, nor should innovative methods be used to the detriment of care given to the greater number of patients (hence the need to evaluate separately the introduction of new technologies and their impact on health caring activities[14]).

- *economic*, in so far as certain items of expenditure could be a subject for negotiation between the authorities and certain economic actors, such as the pharmaceutical industry for example. The drug market is in a state of flux, in particular in the United States which is the main supplier. In that country, insurance companies and official regulators such as FDA (Food and Drug Administration) are seeking new financing strategies for pharmaceutical expenditure[15]; France would be well advised to follow that example.

- *budgetary* (particularly important in the case of very costly treatment or rare resources). The management of organ transplants is a good example[16]. Economists have proposed instruments to judge the equity of allocation (for instance, is allocation effective from the point of view of optimising the well-being of all members of the community); or are the decision processes legitimate, i.e. socially adequate and acceptable in terms of public health? Emergency and Accident and Resuscitation units, psychological support for patients, palliative care and arrangements to accommodate the disabled must also be financed according to specific criteria; these are common support resources serving all the other departments and if their financing is inadequate, the overall efficiency of the hospital suffers a negative impact.

- *geographic*: hospital performance must be evaluated in terms of regional needs, taking into account for example regional morbidity and mortality or local environmental factors;

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[14] In fact the growing disconnection between demands for new technology to be used and health needs can paradoxically lead to discrimination, since the progress of technology tends to make it more exclusive. Technology often encourages over-prosperous societies to be neglectful of human and spiritual dimensions, so that "providing healthcare" becomes more important than "taking care".

[15] Cf. in particular the article in Le Monde, May 2, 2007, "Aux Etats-Unis, les Big Pharma testent de nouvelles stratégies" (In the US, the Big Pharma are testing new strategies).

[16] For further information on the concepts in question, readers could see in particular:

• Jean-Paul Moatti: *"Dons d'organes: Un révélateur des arbitrages entre l'efficience et l'équité dans le système de santé",* (Organ donation: evidence of the choice between efficacy and equity in the health care system.) in "La greffe humaine. (In) certitudes éthiques: du *don* de soi à la *tolérance* de l'autre", PUF, Paris 2000

et :

• Christian Hiesse, Esmeralda Luciolli, and Didier Houssin: *"Les règles de répartition des organes aux malades en attente de greffe. — une évolution dans la direction de l'équité ?* (Rules for the allocation of organs to patients in need of a transplant. - Developments in the direction of equity?) *in "Ethique médicale et biomédicale. Droits, enjeux, pratiques", Revue Française des Affaires Sociales, 3: 181-196, 2002*

- *equity* between individuals in the allocation of cost and care. There are two kinds of equity: "horizontal" (or distributive), meaning that identical cases must be dealt with in a similar fashion, and "vertical" meaning that individuals *belonging to different categories* may be treated *differently* if the community considers that positive discrimination is owed to some according to assessable ethical criteria. That would be the reason for taking into account the criterion of *vulnerability* which, as we have already noted, is not seriously considered at this time.

- *regulatory*, which all too frequently hinders good hospital management. Some medicines are only reimbursed if they feature on a specific list (for example anti-hæmophilic drugs), whereas if they are not on the list, the hospital has to pay the total cost.

- *legal*, guaranteeing universal access to health care. Any refusal to treat a patient for a financial reason is punishable. The cost of treatment is, in principle, never considered except in the case of obvious abuse. This principle is bound to increase costs since the courts tend to side with plaintiffs if there is proof of loss of chance due to the best available treatment at a given time being withheld.

- *media-related*, due to action on the part of patient support groups alerting the media to injustice arising out of refusal to give patients a certain medicine for financial reasons.

- *political*, applied mainly by local authorities rather than central government because in many communities, the local hospital is the biggest local employer, so that keeping the hospital active may be a decision contrary to the best interests of patients as they would appear if cost/benefit ratios had been taken into account.

Reinforcing hospital efficacy and coherence through continuing evaluation

The brief inventory of the various priority criteria given above suffices to explain how difficult it is to apply them; some of them are contradictory and therefore give rise to misgivings on the part of those concerned. It is therefore necessary to make a global evaluation of the cost of hospital activities in relation to their utility for both the medical and social missions of institutions.

But this evaluation is too important for it to be seen as a ritual exercise or even worse a magic formula. The application of any criterion will necessarily be subject to contradiction and generate tension. There is no easy way to choose between quality and quantity, the satisfaction of individual needs or of collective requirements, public service (the general medical missions of hospitals) and the private sector which paradoxically takes on the burden of contracting for costly treatment, routine care in the hands of regional hospitals and the spectacular advances in so-called "prestigious" institutions.

These decisional paradigms force decision makers into unethical choices. Not choosing is a choice in itself, be it deliberate or unintentional, and may well be even less ethical. Global measuring tools (such as the "social health index") have been proposed to broaden the number of parameters entering into the evaluation; they are more suitable

than targeted instruments which are overly dependent on norms of all too frequently questionable objectivity. If the contradictions created by excessive or partisan simplification of the issues at stake are to be overcome, clearer strategies must be adopted, based on methods taking primarily into account documented public health actuarial needs. There must be willingness to apply different or multiple criteria to problems and mutually incompatible objectives in order to achieve this goal.

The importance of not mistaking evaluation for rating must also be emphasised. Rating is a technical action, unlike evaluation which, as we have seen above, addresses the quality of care and services and must also take into account components which can only be quantified with the greatest difficulty, such as for example, those required for discharging the social missions of hospitals. Evaluation is a qualifying activity integrating critical judgment, not only on the performance of services, be they discharged in the hospital itself or outsourced — for example by the use of hospitalisation in the home which is frequently more effective and less costly than staying in the hospital. An evaluation of the cost and the quality of care must be extended therefore to all the sectors involved, including partners in the private sector carrying out public service missions, and also take account of the actual efficacy and advisability of externalising certain services. Finally, it should also touch upon the level of optimisation and coordination of the actions which make it possible to implement these missions.

The most important requirement for an evaluation is that it should clearly single out, in the light of a given economic and budgetary situation and for a given issue:

- the evaluation of the project in relation to Public Health objectives,
- the evaluation of allocated budgetary resources,
- the evaluation of budgetary designations and,
- finally, the evaluation of results.

Ministry of Health plans and new rating instruments

In the last five years, various *plans* developed by the Ministry of Health have succeeded one another, aiming in particular to allocate special supplementary resources to reference hospitals to improved the medical management of certain conditions. The plans were implemented progressively together with the more general "Hôpital 2007" Plan, aiming to reorganise and modernise the management of hospitals and increase their autonomy. A specific section attempted to plan for an expected increase in the demand to cope with loss of autonomy.

The allocation of fresh financial resources was designed to respond to some public health needs which had been identified as priorities or insufficiently resourced in the past such as pain, cancer, rare diseases and Alzheimer's for which special plans were drawn up. Despite the good intentions presiding over the development and implementation of these plans, hospitals were finally left to bear their cost, under the heading of new expenditure, frequently without any allocated budget line, therefore at the expense of pre-existing activities.

The implementation of such plans must necessarily be very carefully evaluated in relation to updated public health objectives, within three to five years following their launch, as stipulated by regulations, both as regards the initial budgetary allocations and results.

A form of evaluation based on the number of beds occupied can for example help to admit patients in a relatively flexible manner regardless of the pathology involved, so that the system can be more compliant with actual requirements. It does however make it more difficult to exert rigorous control over the pertinence and duration of hospitalisation. Inversely, the T2A pricing system (based on price per activity which represents the rating of a service, not an evaluation) [17], which was recently introduced as a new and mandatory regulatory mode of pricing in public and private hospitals, provides more control over health care expenditure in specialised units (oncology, cardiology, immunology, etc.). However, by giving precedence to the accounting of technical services over increased attention to patients' needs or to lengthy and detailed clinical examination, the system tends to rate as "non-profitable" a great many patients in general medicine, psychiatry, gerontology or pædiatrics, where the true cost of medical management is not included in the computation. Measuring what cannot be put in measurable terms (such as for instance, the time needed to examine a battered wife in Accident and Emergency, the time taken to come to a difficult diagnostic decision, to convince an elderly patient to accept treatment or to explain a course of treatment to patients and their family, etc.), is in fact measuring what conditions the success of therapeutic investment and must not be left out of the equation. The importance of such situations should not, on the other hand, become a pretext for obdurate opposition to the philosophy of the reform. On the contrary, it should be reason to reflect on new methods of assessing medical time spent.

Paradoxically, the effects of this method of pricing can also contradict the objectives of regulatory bodies such as the *Agences Régionales de l'Hospitalisation,* in charge of distributing the health care facilities within a region, organising solidarity and encouraging innovation and prevention strategies.

Compared to the previous system, the introduction of the price-per-activity method may have been seen as a step in the right direction. But it is only a tool for *rating*. It is not, as we have seen, an instrument for *evaluation*. Originally, it was a variation of the *Codification Commune des Actes Médicaux (CCAM)* (common codification of medical services). A proper evaluation must include qualitative elements such as quality of life and not just quantitative components, must refer to professional practices as well as outcomes and must contain a reasonable dose of critical "self-analysis" but not be content with "endogamic" or automatic procedures which might systematically eliminate some essential criteria and privilege certain corporatist interests.

One possibility would be to ask an outside body specialising in critical evaluation with teams of competent and recognised evaluators to do the job, for example the *Caisse Nationale d'Assurance Maladie* (French national health insurance scheme). But the suggestion could well be strongly opposed for cultural reasons in view of the dangers of sub-contracting evaluation to professional evaluators[18]. It would probably be wiser to give doctors the capacity to understand and master innovation, and help them make well-considered choices amid the wealth of new technologies to which they have access, with the assistance of structures enjoying good professional credibility such as the *Haute Autorité de Santé* (French National Authority for Health).

[17] Pricing of an activity, i.e. financing *a posteriori* services according to a precise price list taking into account mainly technological investment.

[18] The ease with which a cardiac ultrasound examination can be rated and the impossibility of rating a good cardiac ultrasound examination are gradually bringing about the elimination of the latter...

The challenge confronting all the regulating authorities and health care professions is to preserve both the human component of the "art of medicine" and the quality of increasing complex health care structures. It is only by improving the quality of medical practices that a real "return on investment" will be obtained. Savings generated by combating waste and a better coordination of resources can play an important role and make efforts to improve quality profitable. There are possibilities in this respect for generating considerable margins so that more could be done with no-growth budgets.

These points must be the subject of further study. Finding that the adjustment of activity to generated costs is low may have been a shock. The recent assessment by MEAH *(Mission d'Evaluation et d'Audit Hospitalier* - hospital evaluation and audit mission) shows that if the subject of operating rooms in a technological surgical setting is considered, over 50% of medical staff spend time not "doing nothing", but waiting. The efficiency of care could therefore be improved, which would contribute to a reduction of costs connected to "non quality"[19]. Unlike countries in northern Europe where the policy of systematic error detection in health care systems has prevented the creation of a climate of suspicion, we are still working generally on the assumption that healthcarers can be trusted.

To reinforce and persist in this climate of trust while committing to a policy of constant quality improvement, encouragement is a better option than punishment. Both the organisation of health care and individual practices on the part of healthcarers should be considered. What is important is that the actors themselves adopt a "quality spirit" through an explicit process to be integrated into medical practice. The three methods most commonly used to initiate change (encouragement, punishment and comparison) can work for structures but the most effective tool with human beings remains encouragement with positive valuation of quality.

Finally, the preponderance in hospital budgets of the cost of health carers (nearly 80%) obviously limits a hospital's room for manoeuvre. There can be no question however of trying to solve budgetary constraint problems through a reduction in their number since hospitals are already understaffed. A more effective move would be to review staffing in the light of optimal posting.

4. Conclusions

- The limited nature of financial resources allocated to the hospital system requires ethical choices to be made by the community which should be made public. The *ethical dimension* of these decision-making processes should be clearly identified and integrated in the evaluation methods. Evaluation methods including only quantifiable criteria but neither qualitative criteria nor the ethical dimension would put hospitals in grave danger of dehumanisation and furthermore would lead in practice to increased costs. Making the hospitals

[19] Cf the report published in 2006 by the Académie Nationale de Médecine under the leadership of Georges David and Claude Sureau: "From punishment to prevention. Towards prevention of treatment-related adverse events". Can also be quoted as an example of a project to reduce costs while improving quality, a system launched by a large Pennsylvania hospital group proposing a 90-day warranty on all its procedures. This measure, which has recently been evaluated a posteriori two years after launch, has given rise to substantial savings on surgical outcomes and nosocomial infections, due to more responsible performance by all hospital healthcarers concerned.

shoulder alone the burden of political choices, which concern society as a whole, is neither legitimate nor equitable.

- The concept of profitability cannot apply to hospitals as it would to ordinary commercial activities. In the health sector, any process of evaluation, irrespective of its particular technical worth, must take into account the fundamental missions of hospitals and the frequently contradictory and conflict-laden interests of the health care system's "clients", depending on whether these patients are using either the social facet of hospitals or the therapeutic and technical facet involving advanced technical treatment, or both. However, and to the same extent to comply with rules of good management of public monies for the sake of national solidarity, the process should also include an evaluation of professional practices based on recognised standards.

- Nor should evaluation be an obstacle to patients exercising their right to free and informed choice, as this is sometimes called into question by conditions of a different kind (such as occasionally the prior authorisation for the use of certain therapies or certain medicines). These conditions must be defined through consultation between political authorities and the social partners. In such cases, the medical profession cannot avoid the need for economic control of its activities in the name of freedom of prescription. Evaluation which is not followed by implementation ends up being meaningless. The low standard of palliative care in France (which is still unrecognised by universities) is an example of a striking discrepancy between theory and practice.

- As is the case for any other economic and financial assessment, a hospital evaluation must balance out costs and revenues, assets and liabilities. But in this case the benefits for the community are not just limited to therapeutical acts listed in the T2A scheme performed by staff in the hospital under evaluation. Hospital activity can generate income and profit in other sectors. This is the case for technical, biological or pharmaceutical care provided for outpatients or for other health care institutions and is also true for the development of new diagnostic and therapeutic techniques (frequently in cooperation with university teaching hospitals) which, in the long term, may contribute to an overall reduction of the cost of medical management of certain disorders and furthermore give rise to filing patent applications. What is very positive — and should be even more so — is the effect of the Health Prevention and Education projects. A number of studies have reported that they have a positive economic impact, both on direct and indirect costs (in particular due to better treatment compliance and a reduction of absenteeism). Expecting hospitals to solve unaided all the problems arising out of precarious living conditions is simply a refusal to take these problems on board. Their solution needs to be addressed either before or after hospitals are involved. In fact, not taking care of vulnerable members of society living in precarious circumstances generates various indirect costs for the community[20].

[20] As Jonathan Mann reminded us, the inextricable link between health and human rights is not an ideology; it is an exploration which calls for a sufficiently coherent and significant vision of society for it to sponsor new creativity and new energies in an effort to ensure for everyone conditions conducive to physical, mental and social health to the fullest extent possible. Human rights are only ideas and words, but they are uniquely powerful ideas which can change lives and the course of history.

- Healthcaring tasks incumbent on hospitals are naturally numerous and not limited to diagnosing and treating diseases. Medical and social components should be much more clearly identified and separated. What is not easily evaluated by quantitative criteria must be approached according to other models, yet to be defined, and implemented on a continuing basis. This requires the combined expertise of economists, physicians, sociologists, psychologists and possibly philosophers in configurations which could be structured by bodies such as the *Caisse Nationale de Solidarité*. Exceptional expenditures for rare diseases should be evaluated and borne by specially funded systems. Such funds would need to be financed on the same principles as those of the *Caisse Nationale de Solidarité* and all those concerned would need to network with those specific aims in view.

- None of the existing evaluation systems can cover on its own all the missions assigned to hospitals. T2A was the consequence of an evaluation of the technical tasks involved in diagnosis, medical treatment or surgery. But it is probably inadequate for other activities such as the medical management of chronic disease, follow-up care, palliative care, treatment of the elderly or of sick children and preventive action, since it does not consider the time spent on hearing patients out and thorough clinical investigation. Other criteria which take account of the qualitative aspects of health, such as for example, time spent on listening to patients and providing them with information, should be defined to evaluate the non technical services provided. It is not so much the T2A system itself which is under criticism as the definition of "a medical action".

- Teaching and research activities, particularly in the university hospitals (CHU), are essential for maintaining and developing an efficient hospital system, and that is where they should remain, but they must be the object of specific evaluation and budgeting, which does not mean external financing. In fact, the university hospitals are major actors in biomedical research and must contribute to financing these activities. The issue, therefore, is not so much identifying specific financial resources, which is always very difficult to do because of the closely interwoven relationship between health care and research, but to recognise as an important fact that this is their essential contribution. This is also true of Health Care Prevention and Education services which develop in parallel with scientific advances. Such financing should be considered separately and timed in relation with expected results.

1. Recommendations

CCNE recommends:

- re-integrating ethical and human considerations into health care expenditures, so that hospitals can discharge all of their missions equally without focusing entirely on the more spectacular and technical facets. Clinically speaking, the notion of *sober medicine*, as opposed to *redundant medicine* should be given prominence. Redundancy disguised as precaution is only too often a mask for intellectual laziness and for reluctance to shoulder the responsibility of difficult decisions.

- adjusting the scales for evaluation of hospital activities so that the various missions can be dealt with appropriately. For this purpose specific models should be developed for each of the principal care objectives: technical actions, non instrumental activities such as prevention and health education, medical management extended to all patients in the name of solidarity and social cohesion and also research, innovation, diagnosis and therapy.

- reconsidering the essential and primary missions of hospitals. The original missions — providing assistance to all those who are vulnerable or in poor health, and research and teaching tasks — seem to have receded in recent times so that hospitals are now increasingly an industrial and commercial public service with the consequence that absolute primacy is given to economic profitability to the detriment of a continuing social dimension.

- giving hospitals an added dimension encompassing both "health" and "social" factors (dependency, adolescence, precariousness, etc.), by promoting cooperation between hospitals and external structures, such as long-term nursing homes, home hospitalisation systems and prison hospitals, as part of the G.E.S. (*groupement de coopération sanitaire*/health care cooperative group), with emphasis on personalised solutions and special individual circumstances (childbirth, extreme precariousness).

- ensuring continued social cohesion so that people do not sink into exclusion once they have been diagnosed and treatment begins. Is there any logic in winning the medical battle if social death is the outcome?

- giving the greatest attention to mental disorders which should become a priority since they are the archetype of pathologies spanning medicine and social issues, biology and the environment, individuals and society.

- refraining from using rating systems where they are not particularly pertinent: the T2A when it is applied to such medical activities as psychiatry, gerontology and pædiatrics, where unhurried attention and thorough clinical investigation are necessary to comply with recommended practices. Different criteria should also be used to judge other hospital missions in public health which the T2A is unable to evaluate and therefore value correctly. Qualitative components should supplement (or complement) the evaluation system to avoid the trap of "quantitative tyranny". The T2A valuation system should therefore be restricted to specialist technical actions for diagnosis and medical treatment.

- making sure that "care" (taking care, devoting attention) is not neglected while "cure" (treatment) becomes the exclusive objective. The example of palliative care is emblematic. It is encouraged by law, but there are no provisions for its implementation. Hospitals *repair* the sick, but patients many be in need of other services, such as follow-up, which is one of the strong points of the *Caisse Nationale de Solidarité.*

- re-integrating the political dimension into the formulation of priorities instead of relying solely on hospital management decisions. More in-depth consultation between decision makers and all other health care participants would be

required, creating effective and ongoing partnerships between all concerned. Bodies such as the *Haute Autorité de Santé* (Independent Administrative Authority) or the *Groupements Regionaux de Santé Publique* (Regional Public Health Groups whose tasks include registering the state of public health in a region) should be involved.

- Finally, considering a hospital's social environment. A vulnerable environment should give rise to specific reorganisation of resources to adapt to the actual circumstances.

In conclusion, guaranteeing fair access to quality health care is not incompatible with economic orthodoxy. The constant need to adjust health care to demographic requirements, epidemiological changes and technological advances is ample justification, more so than for any other human activity, for clear and courageous choices, which must be explicit in the eyes of citizens. Such decisions must be kept under constant review without ever losing sight of the central core objective: helping the most vulnerable.

The ethical issue raised by an examination of the economic dimensions of health care is an exploration of the tension between autonomy and solidarity, between individual liberty and the public good. Such tension can only be relieved by seeking equity, in other words, justice.

June 28, 2007

Annex 1

Health care expenditure in relation with GDP

It may be instructive in considering this difficult and sensitive issue to compare the general situation in France and that of similar countries. OECD produced a fully documented report on the subject in 2004 from which three salient points can be drawn:

- With 9.5% of GDP (Gross Domestic Product) allocated to health care expenditure, both public and private, France is one of the highest-spending developed countries. It is only surpassed, and not by much, by Germany, Canada, Switzerland and far away in the lead by the United States with nearly 14%.
- France is also one of the countries where the public financing share of health care expenditure is highest (76%); it is outdone by several Nordic countries where this figure exceeds 80%, but these countries devote a lesser proportion of their global resources to health.
- Combining these two sets of data shows that France is, apart from Germany (which has radically revised its policy in the meantime), the OECD member country where public health care expenditure was highest in relation to GDP in 2001.

Even though, as is always the case with international comparisons, such data does not claim to be strictly exact in accounting terms and would need updating to reflect conditions in 2006, the main thrust of the finding is still very certainly valid. Furthermore, as public deductions from the GDP in our country are at a very high level, it is quite clear that the margin for possible increases in public health expenditure (over and above the annual progression of GDP, i.e. more than 1.5 to 2.5% per annum in real terms) is limited.

Annex 2

On these various subjects, there are references to be found in experiments and research for an equitable solution in a situation where selection was mandatory. Examples of research in other countries come to mind such as efforts to improve the management of waiting lists in the British system[21] or in Scandinavian countries and recommendations by the Council of Europe[22] based on various experiments. This document studies the main causes for waiting lists, their usefulness in planning admission for treatment and the importance of using exact and accessible data in order to allocate efforts to best effect and improve the quality and organisation of health care. On a national level, it is clear that certain practices must be avoided at any cost and that some problems would benefit from in depth study.

[21] Cf: Jon ELSTER (dir) 1994. The Ethics of Medical Choice. Pinter Publishers

[22] Council of Europe: Recommendation n° R(99) 21 Committee of Ministers to member states on Criteria for the management of waiting lists and waiting times in health care (adopted by the Committee of Ministers on September 30, 1999 at the 681st meeting of Ministers' Deputies);

- Criteria for the management of waiting lists and waiting times in health care - Report and Recommendation No. R (99) 21 (2000).