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A Critique of the Limiting Consequences of Current Thinking in Healthcare and Proposals for the Next Millenium: Reflections on the Catallactics for Integrated Healthcare Delivery

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The recent BUPA Health Debate 1997 (World Medical Association, 1997) makes stimulating reading. Five eminent panelists debated the motion *"The existing UK healthcare system can survive the next 50 years."* The audience of 350 people represented the medical profession, politicians, policy-makers, purchasers, and providers of healthcare, as well as representatives of business and healthcare management. By a small margin the vote taken at the end of the debate showed that the majority did not believe the existing UK healthcare system could survive. After the panel discussion, the issues of the debate were opened up to the audience and three controversial topics emerged and were also voted on:

1. The majority thought that in future the public should be prepared to pay higher taxes to finance the current level of healthcare services.
2. Most said the money should come from hypothecated tax, which means, in simpler terms, they were prepared to have Government pawn future tax (*ie*, an additional dedicated tax that has neither yet been levied nor collected) to cover present healthcare expenditure.
3. A great majority felt that if healthcare rationing must take place, the responsibility for rationing should be shared jointly four ways by (1) Central Government, (2) the medical profession, (3) the public, and (4) the National Health Service management.

A closer look at various aspects of the economics of the existing model and then manipulating these into what may be a thriftier model should be a worthwhile exercise.

The Government's inability to foot the bills meets the conditioned inability of citizens to fend for themselves and precisely this contributes substantially to the current deadlock. Twenty years ago an economist pointed out that individual responsibility for personal health is a *sine qua non* (Dixon, 1978), because restoring and/or maintaining health is, in economic terms, mostly a *demand* function and not, as some would have it, always a *need* function (more of this below). This would require reeducation of the general public away from the existing conditioned reflex to delegate to Central Government all individual responsibility in matters of health and disease. *Health creation and maintenance by the individual* would need to be the new watchwords. This should to some extent reduce the current insatiable (and still growing) demand for firefighting pharmacotherapeutics.

Where maintenance of anyone's health is impaired by forces outside the influence of the individual concerned, provision must be there for dealing with this, within a framework of which this individual is a part, such as the National Health Service (NHS). Yet it is right that those who will have a claim to assistance in circumstances for which they could have made provision, should always be required to make such provision for themselves (Hayek, 1976).

The Hale Clinic, London, England.

There is a need to re-educate the medical fraternity too. Changing healthcare from the "let's fix it" to the "let's stop it for good" approach can readily be shown as better serving the practitioner's interest and stimulating self-development and autonomy because it creates a considerably greater demand on the medical professional than mere routine drug prescription. The current perception is that *curative* medicine is more heroic, exciting, interesting because it is interventionist, but that *preventive* medicine is simply uninspiring. This view rests on a spurious either-or dichotomy. It is generally accepted that the physician's responsibility to the patient at all times is to provide the best healthcare available. This includes: removing the cause of conditions, when known; choosing treatments that pose the least risk of harm to the patient, while offering the best prospects for a complete cure; individualizing treatments to the whole patient, leading inevitably to referrals for appropriate adjunctive health resources in specialized therapies (say, pain relief through acupuncture to run alongside a course of osteopathic manipulative therapy); educating the patient to participate in his or her own healthcare by learning the principles for building and maintaining health and the prevention of future illness; and involving, when appropriate, others significant to the patient (ie, the spouse) in the treatment plan (Pizzorno, 1993).

"Evil," or "criminality," is generally deemed to be a product of an individual's choice and, therefore, something for which he or she is held responsible and can be punished. By contrast, once judged ill, a patient is said to be disabled and absolved from ordinary responsibilities of everyday life. In Western societies one would not be punished for that. But can one disown responsibility for one's ill health as simply as that (Kennedy, 1981)? If one starts from that ethical premise, does that mean in the UK context that someone who is a tobacco smoker is knowingly contributing toward a greatly increased personal risk of myocardial infarct, stomach ulcer, emphysema, or a variety of cancers, and thereby becoming a burden on the state, ie, the taxpayer, and is ultimately contributing to the need for rationing in healthcare thus depriving the next person of healthcare? Is this free choice, couched in irresponsibility, which brings about a heavy burden on the community later (that of becoming NHS-dependent) if not actually criminal? Prevailing ethical interpretations of the concept of responsibility within society, if logically extrapolated, would then also have to condemn many widespread eating and drinking habits as quasicriminal occupational hazards, the systematic promotion of pharmacophilia, industrial food adulteration, environmental pollution, and, by extension, all nonsustainable overexploitation, as well as many other destructive or degrading human activities. Western society's cynical view of the end product is semantically rather neatly encapsulated:

> **IN**valid has the same root as in **VALID**—the change in pronunciation helps to hide the harshness of the implied judgement that reflects Western values of production and economic worth (Kennedy, 1981).

The *only* way forward seems to be for individuals to take responsibility for personal health. The 11-year growth of enterprises like London's *Hale Clinic* (with its ± 132 constantly busy physicians, practitioners, and therapists, functioning entirely within complementary and alternative medicine [CAM] at all times) bears testimony to the fact that this is now happening on an exponentially increasing scale. The administrators of, and more particularly the professionals within, the existing conventional healthcare delivery system have become alarmed by this phenomenon and would wish to harness CAM within their system. It is becoming evident that this could entrain a variety of previously unforeseen economic changes along with it, in effect creating an entirely new integrated healthcare system.

The economic issues to be considered for such a cohesive new system to be put in place that would further health creation and health maintenance are: how to make available the most effective and economic health creation and health maintenance provision that is both just and equitable; and how to make it possible for this to exist alongside the NHS provision by the State (although the NHS may become both ineffective and uneconomic).

Such a functioning *'Illness prevention through Health Promotion'* system needs to be viable, affordable, manageable and effective. There is ev-

idence that many smaller CAM-conventional medicine centers serving local communities would be greatly superior to the older mammoth-style hospital services, but it means there would have to be cost containment. The five traditional ways for cost containment in healthcare provision are: (1) reducing demand, need and desire for a quick-fix NHS; (2) influencing public health—food, sanitation, housing, work safety, etc; (3) creating a functioning *Illness Prevention System;* (4) concentrating on educating the young; and (5) catering for the elderly.

It seems very likely that elements of all these would need to be combined in one single system. Yet the system is doomed to failure if it does not obey the two most powerful market regulators—undistorted price and the normal checks and balances of competition. An example of price distortion is when medical practitioners do not have to take full responsibility for the costs they are generating (Abel-Smith, 1975).

Evidence for the contention that preventive healthcare is cheaper than awaiting the need for curative medicine later is very convincingly set forth in the well-argued 155-page record of the American Association of Naturopathic Physicians' *Contribution to Healthcare Reform,* which is the full submission made on the April 1, 1993 by the AANP to Mrs. Hillary Clinton's Task Force for the Revision of the US Healthcare System (Pizzorno, 1993). The European Parliament has recently voted EU funds for research into CAM because it accepts that CAM can provide a more cost-effective healthcare base, but so far the EU Commission has only released small sums to finance intranational meetings by professional bodies to harmonize and clarify standards, etc so that such future research could be uniformly acceptable within the EU. In line with the evidence that prevention is cheaper than cure, the present financial and economic incentives in practicing *curative* medicine and disincentives in practicing *preventive* medicine will need to be fully reversed in new CAM-Conventional Medicine Centres' remuneration, promotion and other reward structures. There are three systems of remuneration in existence: (1) the medical, nursing and other practitioners are paid a salary; (2) remuneration may be on a capitation fee; or (3) it may be on a fee for service basis (FFS).

A salaried remuneration promotes mediocrity and breeds employee behavior; it also discriminates against the better practitioner and leads to shortage of professional personnel that drains away to more lucrative opportunities. If the total CAM-conventional medicine centers system were to work on salaries, the quality and variety of service would ultimately be limited only by what patients will accept they need. Salaries remove the incentive to save and promote wastefulness. Finally, salaries encourage referrals, which escalate costs.

In payment based on capitation, time becomes the dominant factor. There would probably need to be a sliding scale, based on number of patients kept healthy, in order to modulate the current incentive to push through quantity. Seniority ought to be acknowledged in the per capita fee unit. A modicum of profit-sharing may be an additional incentive to assure quality.

The FFS comes closest to what a *laissez faire* free market system stands for, virtually all nonorthodox medical practitioners (ie, naturopaths, osteopaths, homeopaths, phytotherapists, practitioners of Oriental or Ayurvedic or Unani or African medicine, and chiropractors) as well as all the complementary therapists (masseurs, hypnotherapists, healers, reflexologists, etc.) operate on this basis in the UK and Northern Ireland; however, the catallactic economic effect (von Mises, 1963) of a relative oversupply of practitioners (due to unrestrictable influx from seriously oversupplied parts of the European Union (eg, France has over 7000 medical doctors on the dole, the situation is slightly less severe in Austria and Germany) where nonorthodox medicine has long been part of the social fabric and medical culture, could quickly result in a relative patient shortage. According to the same effect, diverse sales-promoting devices may then make their appearance, which could trigger the proliferation and utilization of novel, designed-to-impress, perhaps unproved, methods and equipment. FFS offers absolutely no incentive for referral, strongly tempting practitioners (and even therapists) to do interpretations and interventions which may exceed their qualifications. FFS promotes specializing as a method of maximising income (applied kinesiology,

cranio-sacral techniques, or electrodermal allergy testing are possible examples) and it encourages the use of wastefully unnecessary diagnostic tests and unwarranted intervention (eg, needless surgery, or unjustified return appointments to the colon hydrotherapist or acupuncturist). FFS necessitates costly, lengthy and complex procedures for negotiating a system of fee refunds based on agreed tariffs with medical aid societies.

The conclusion would appear to be that the capitation fee is most appropriate in the setting of the envisaged new CAM-conventional medicine centers.

Medical aid schemes are inherently inflationary. They violate the economic principle of real price by shielding patients from health costs (Randall, 1980). They add to the cost of healthcare and do not offer any incentive for financial discipline; their main beneficial function, however, is to even out illness costs to members over time. There is no other system in existence that would offer the advantages of cover and free choice of care without the disadvantages of inflated administrative charges. At this time there is a near-market duopoly in the UK held by BUPA (British United Patients' Assurance) and PPP (Private Patients' Plan) and, inevitably, serious diseconomies of scale have arisen. These schemes have penetrated deeply into various aspects of healthcare delivery (like the UK's breweries into the pubs, bottle stores, restaurants, and hotels), which has subtly eroded the autonomy of some healthcare professionals in those areas.

The compulsory guarantee of payment to suppliers of medical, dental, nursing, and CAM services at unspecified tariffs is viewed like a blank endorsed check in someone else's hands, but medical aid schemes would need to accept that they have to contend with that (Erntzen, 1980). Controls on tariffs are price distortions. Suppliers of professional medical services are well placed to set their own tariffs and if there is genuine competition between them, the realistic price for services must emerge, whether in the FFS or on the capitation system. There now also needs to be a radical containment of rising insured (private) healthcare costs. For this, as well as for most of the other problems raised above, the envisaged new CAM-conventional medicine centers could adopt a fresh economic approach in the UK. These CAM-conventional medicine centers should assume a contractual responsibility to provide, or insure for the guaranteed delivery (if need be elsewhere) of, a stated range of health services to an enrolled defined population group in its catchment area. This would require a fixed periodic payment to the particular center to which an individual is voluntarily attached. That payment would be due independently of the use of the centers services, the partnership of physicians, practitioners and therapists at the center assumes (at least part of) both the financial risks and/or gains in the provision of services. It has been calculated that the cost saving could be up to 40% over any standard insurance-based coverage (Luft, 1980).

A further source of potentially increased cost efficiency would be derived from the inclusion of the CAM healthcare professionals, who automatically bring with them a strong emphasis on preventive medicine. Such a system will immediately avoid unnecessary duplication of services (the bane of the NHS). The new CAM-conventional medicine centers could be sponsored by large commercial insurers, trade unions, employers, multispeciality groups, consumer groups, guilds, municipal agencies, fraternal organizations (like the Freemasons), sections of the community (eg, Jewish, Polish, Irish), religious denominations (eg, Muslims, Catholics), and even for-profit management firms (the sponsor could influence the objectives and the selection of the professional staff). The new CAM-conventional medicine center system would attract research funding because of its natural built-in cost controls. Above all, the centers would alter the usual financial incentives in medical care by giving the care providers—this is both fundamental to the concept and absolutely crucial to its ultimate success—an automatic stake in holding down costs. Simply put: the healthier a particular centers contributor-members, the more net profit accrues from the subscription fees to the center and to its practitioner-shareholders. There are echoes here of the story of the Chinese doctor who is only paid by his villagers as long as they are healthy, but anyone falling ill stops paying that doctor until the doctor makes that person well again.

The new centers' contributor-membership can have an elective modular aspect. It would be possible for a member to enroll only for a selected segment of healthcare; for example, only for the pre-, peri- and postnatal segment of healthcare (Hickock, 1992). The centers could also offer special care for the growing 65-plus age group in aging Britain. The elderly would do particularly well on the softer alternative therapeutic approaches to be prevalent in the new centers. Older people often react rather severely to harsh medication, which then requires costly corrective medical NHS intervention. Drug-induced malnutrition, drug-induced incontinence, drug-induced impairments of cognition and mobility, drug-induced depressive disorders are all described in the authoritative *Practical Guide to the Care of the Geriatric Patient* (Ferri and Fretwell, 1992). Special imaginative mortgage arrangements could make center membership available to some of the elderly.

A contractually pre-agreed second-opinion arrangement could reduce the amount of unrequired treatment insisted on by patients against the better professional judgement of center's practitioners and of a CAM-conventional center's practitioners withholding genuinely needed treatment. Similar minutiae (like a practitioner giving unrequired treatment, or moving away and abandoning patients, or a patient losing confidence in a practitioner for whom there is no understudy in the local center, or a patient moving to a distant area, etc) could be safeguarded against along the lines of the time-tested solutions to similar problems by the Incorporated Law Society.

The objection is sometimes raised that restoring health is a *need* function, and not a *demand* function, and that this means that the normal demand-price-supply sequential relation could not obtain to healthcare. And this is said to be more particularly so in the case of drug prescription or hospitalization, where a third party, the prescribing or referring physician is interposed between buyer and seller (Hobson, 1979). Not so: the physician is the seller. The argument may be put another way, that health is a *need* function and consequently falls outside the forces of the free market. Health restoration is seen as the entitlement of all citizens for which Government must shoulder the financial burden. If this is so then *hunger* is a need function or a disease for which constant daily provision must be made by the state for every citizen. This is not done anywhere except in very extreme circumstances when it has indeed become a need. There are many need situations: accidents, fires, floods, disabilities and other catastrophes—nobody wants them, yet they arise. For such contingencies the market has developed (often profit-bearing) insurances. "The essence of insurance is to increase the security of a large number of people by pooling the risk of major catastrophes that will strike only a small proportion of them" (Ehrbar, 1977). The new CAM-conventional medicine centers would do exactly that.

Economics is about making the *best choices* in using scarce productive resources. It has been pointed out that "the most obvious defect of the current medical system is the lack of interest it has shown in prevention" (Inglis, 1981). Richardson, in the *Oxford Companion to Medicine,* makes a clear value judgement on this issue, when he states: "Physicians at the local level have had no particular inducement to be concerned about the cost-effectiveness of the combination of resources being used. An exception to this generalization would be those physicians practising in health maintenance organizations. One finds a striking contrast, for example, between the behaviour of physicians in an organized pre-paid group setting on the one hand, and those in the community in independent fee-for-service practice on the other" (Richardson, 1986). The concept of the organized pre-paid group practice as envisaged for the new CAM-Conventional Medicine Centres has received a fair amount of favorable attention in the economic literature (Brown, 1983; Falkson, 1980; Kay, 1979; MacColl, 1966; Mackie and Decker, 1981; Oatman, 1978; Shouldice and Shouldice, 1978; Spier, 1982). In 1976 the UK Government undertook a policy initiative to help resolve the question of how to allocate money to healthcare. A major consultation document was issued, entitled *Prevention and Health: Everybody's Business.* It proposed a shift in expenditure from the acute hospital sector to preventive medicine and health promotion. The proposals were widely accepted, since it was agreed that for too long the hospital-

based acute services had taken a disproportionately large share of NHS expenditure (Cook, 1987). Yet despite the broad support, no real advance was made in preventive medicine, very probably because the necessity to reverse economic incentives for the healthcare providers was overlooked, or was considered to be of no consequence.

Cost calculations might include contingency margins that could provide a constant reasonable flow of funds towards CAM (undergraduate and postgraduate) education as well as for research and development. Furthermore, the economic considerations behind the new CAM-conventional medicine center concept should not merely strive to achieve the most cost effective healthcare and health maintenance delivery system, but the concern would also extend to the full impact on health production, by virtue of other inputs, like contributor-members' earnings, nutrition, and education in overall health creation (Maynard, 1986).

Successful innovation requires vision, conceptual clarity, good timing, a conducive political climate, and sound economics—it seems we may have all this right now in the UK for our drive toward integrated healthcare.

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