Hong Kong Society of
Health Service Executives
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Hong Kong Society of Health Service Executives 2004/05

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Editorial

Ethics, Economics and EQ in health care

A few years back when I was studying at the University of Minnesota, I was surprised to note that there were millions of Americans without access to health care. The situation is the same today. Given that I often equate Americans as the "haves" and rich nations like the United States of America would allow its citizens to be deprived of health care, was almost "unthinkable" to me.

Today, health care managers make decisions everyday that will affect the lives of people all over the country. Do we take each decision seriously and do we know that sometimes our decisions may be morally well intended but are economically unsound. On the other hand, we may make health care decisions that are economic miracles but are ethical mishaps!

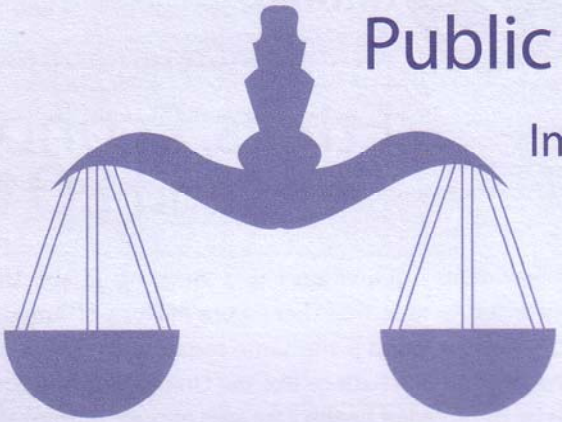
Medical Ethicist Merrill Matthews has coined a new term " ethinomics" to describe the point at which ethics and economics converge in the public policy arena. Increasingly, we need to recognize that ethics and economics are perhaps two sides of the same coin. In any case, any decision needs to be implemented and whether it is a closure of a hospital, a merger of two hospitals or the building of a new hospital, we need to be mindful that the "intelligence" required in implementation of the change programme requires another "E" and that is "emotional intelligence". Hence the equation of a successful change programme in health care should be based on decisions that are systematically analysed; using sound ethical and economical principles and implemented with a big dose of emotional intelligence. However, the devil is always in the details and I guess I am not an expert to conclude if the "moral cost of using embryos in research is outweighed by the social good that could ultimately result from the work" – perhaps the issue is too complicated and there is no mathematical equation that we could rely on to come to this decision.

Without an exact formula to work out the details, the mental exercise that we subject ourselves in the course of our deliberations would be good enough for the time being. By the way, I wish more Boards would discharge their governance functions by debating these issues at their Board meetings rather than looking at balance sheets. I am sure it would be more fun!

Margaret Tay
Editor ■

Message from the Chairman

Some Thoughts on Public and Private Imbalance in Healthcare



In no time after the new Secretary for Health, Welfare and Food of Hong Kong SAR had been appointed, zealous interest groups and stakeholders began to send him their demand lists. One of the most frequently quoted pitfalls of the Hong Kong healthcare system that requires immediate attention is the so-called phenomenon of "public-private imbalance". While the term may appear straightforward at face value, I find that on deeper reflection, it deserves further deliberation on its actual meaning and implications before we decide on the solutions.

Epistemologically speaking, when we describe something in the negative sense, we must first have a clear idea about the desirable state. For example, if we say a girl is ugly, obviously we must have a well-conceived impression what a pretty girl looks like. So by the same token, when somebody talks about "public-private imbalance" of the healthcare system, he or she should be able to define clearly a state of "public-private balance". But is this the case in reality? So far nobody, those who keep on repeating the term with righteous dignity included, have ever done it. In fact, "public-private imbalance" has become a clichéd word with different meaning for different people.

First of all, we are not told what the meaning of the word "imbalance" is. In want of a better definition, I have to treat the word as a metaphor with reference to a weighing scale. Thus an "imbalanced" state is one showing a bias of the scale to one side. As a corollary, a "balanced" state is one when both sides of the scale are equal, or at least roughly so. I must admit this is just my assumption, as we seldom hear Americans talking about "public-private imbalance" when the private sector is the major player of their healthcare system.

Even with my arbitrary definition of the word "imbalance", we still cannot assess the validity of the whole term because we are not sure against what parameter is the healthcare system judged for being balanced or not. Are we referring to the total expenditure (in money terms) in each sector, so that a balanced state refers to equal expenditure in both public and private healthcare sectors? If that is the case, then we are barking at the wrong tree. Indeed, according to the Harvard Report1 published in 1999, the expenditures for healthcare in public and private sectors were not that different (54% Vs 46% for 1996/97).

If expenditure is not the right parameter, are we talking about number of hospital beds? That sounds likely, as the number of hospital beds in the public sector grossly out-numbers that of private sector. But we must bear in mind that nearly all emergency cases requiring ambulance care go to the public hospital, and almost all beds for communicable diseases, mental health, hospice and infirmary patients are within the public sector. Understandably the public sector requires more hospital beds for these services. Furthermore, is it legitimate to extrapolate the number of hospital beds to represent the whole healthcare sector? After all, the number of private clinics also remarkably out-numbers that of the public sector. So are we talking about a state of "double imbalance" with either side losing in one aspect? Apparently that is not the meaning of those who are crying foul on this matter.

Another possibility is to use the number of clinicians in either sector as a weighing measure. But in actual fact the number of clinicians working in the private sector is more than that of the public sector. In this sense the scale favours the private sector, not the public sector. Indeed this is the argument of some public sector proponents of the imbalance theory. The imbalance they are referring to is the disproportionately heavy workload shouldered by a public doctor when compared with that of their private counterpart. But from what I observed of the private doctors, most of them are working very long hours, and rarely could they enjoy long vacations unlike their friends in the public sector.

How about comparing the total number of patient encounters in each sector? The problem with this approach is the lack of reliable data for the private sector. Even if such data is forthcoming, how are we going to compare the weighting of a clinic visit, a ward round consultation, an operative intervention or a diagnostic procedure? We need an agreed conversion methodology to convert all encounters into a common unit for summation purpose before we can say there is an imbalance between the two sectors.

So what is the real meaning of "public-private imbalance"? I have to admit my bewilderment about this term. I sincerely hope that the term is not used to mark the difference between the income of public and private doctors. If so, then to be correct accounting-wise we must first design a precise and reliable method of computing the average net wage per working hour (after deduction of income tax and all operational costs) for public and private doctors in order to have a meaningful comparison. That sounds an awfully difficult task. I doubt if the Inland Revenue experts can provide the accurate answer.

The only option left for me is that next time when I meet someone talking vehemently about public-private imbalance in healthcare, I will request for a clear delineation of his "balanced healthcare system" before venturing any humble response.

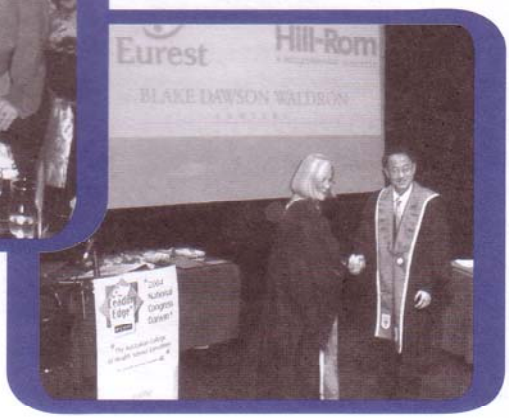
[1] *Improving Hong Kong's Health Care System: Why and For Whom? By The Harvard Team, pages 25-27.*

Dr MA Hok-cheung ■

At the Leading Edge

The Australian College of Health Service Executives

2004 National Congress in Darwin 20-22 July



This year's ACHSE conference was held in Darwin, Northern Territory of Australia. Our HKSHSE sent a delegation of seven members to attend the conference. Because Darwin is not a business hub, we had to take 2 long flights and nearly 24 hours to get there. But the hassle of traveling is worthwhile in view of the knowledge and experience gained from this trip.

We were invited to a pre-conference workshop on quality and safety. At the workshop, participants from the United Kingdom and Hong Kong presented how quality and safety was built into the health care system and structure. The workshop was followed by a visit to the Royal Darwin Hospital which is a 300 beds hospital with 1,400 staff. The total population of Northern Territory is 120,000 and 100,000 of its population live within the 50 kilometers radius around Darwin city. The Royal Darwin Hospital was the first receiving point in the country for the victims of the Bali bombing.

The Ron Tindale Oration was delivered by Professor Helen Garnett, Vice Chancellor of Charles Darwin University, and the Keynote Address was delivered by Mr. Charlie King, presenter at Australian Broadcast, Darwin. I would like to highlight some of the key points presented by the speakers at the workshop and conference.

Quality and Safety

- Build a safety culture
- Shift from individuals' behaviour to work environment
- Must match resources to care needs
- Recognise 'Fatigue' in staff
- Build trust and a no blame reporting culture
- Measure safety and performance
- Strengthen leadership training and development
- Do root cause analysis of sentinel events
- Carry our remedial actions in timely manner
- Disclose performance information to public
- Involve consumers in safety and standards
- Share clinical decision making with patients
- Educate patients and media

Healthcare to Indigenous People

- A challenge to deliver service to a widespread population
- A seven hours drive from Alice Spring to reach a population of 200
- Despite the difficulty and high cost, the government will not encourage people to live in urban areas
- The Aboriginal people have high infant death rate and low birth weight
- Aboriginal male life expectancy is only 54 years old
- Aboriginal health indicators are of fourth world status even though they are living in a developed country
- Innovative models of health care to overcome the challenge
- Telecommunications and community outreach nurses are widely used
- Try to train and develop local people to serve the Aborigines

Leadership

- Better leadership would lead to better patient care and staff performance
- There are leaders for different areas
- Take in trainees from minority (ethnicity and gender)
- There must be Succession Planning
- Research to develop evidence-based leadership development program
- Cope with the increasing complexity in healthcare by continuous training of managers
- Leadership capability can be enhanced by lifelong learning
- 'Leaders keep their eyes on the horizon, not just on the bottom line'

Aged Care

- Increase in elderly population leading to a more diverse group with diverse needs
- Care needs must be planned for short as well as long term
- Diverse in wealth, income and assets
- Diverse in culture and education level
- Diverse in gender and family structure
- Care with flexibility and choice
- Older people's decision should be respected
- Services must be interconnected, accessible and affordable
- Three of our delegates were conferred Fellows of the ACHSE at the annual general meeting. Our conference reception was held on the lawn of the Parliament House and the conference dinner was held at the Aircraft Museum. We sat next to a RAAF WWII air fighter.

Cost-Effective Analysis: An Ethical Evaluation

Cost-effectiveness analysis (CEA) is a major method in health care economics and it has also evolved as a widespread tool for health care policy makers and administrators in determining resource allocation and health care priorities. Information about cost-effectiveness is important to allocation decisions about incurred costs of specific health care benefits. A well-known example in CEA showed that if Pap smear examinations are offered yearly rather than every three years, the cost per additional cervical cancer detected is over US$1million (Eddy 1990). Although CEA is a powerful tool for medical decision making, it is not without limitations such as failure to account for many important social values related to health care resource allocation and priority-setting. This article will evaluate the limitations of CEA from an ethical perspective.

Basic Assumptions of CEA and the Problem of Distributive Neutrality

Cost-effectiveness analysis in health care decision making includes the following four fundamental principles (Nord 1999, Ubel 2000):-

P1: The values of utility gains of a given size are the same, irrespective of the initial condition of the patient.

P2: The utility gain of a health care service is proportional to the number of people who get to enjoy a particular benefit.

P3: The utility gain of a health care service is proportional to the duration of the benefit produced by the service.

P4: The most desirable outcome is one that maximizes the total utility gain within the given budget (the principle of maximization).

The application of CEA is impossible without a common unit to measure the utility gain of different health care services for different patients. Quality-adjusted life-year (QALY) is widely used as a unit of utility measurement for CEA in health care decision making.

The major shortfall for CEA is the problem of distributive neutrality as the fundamental principles assume that societal value is an unweighted sum of individual health benefits, which implies that the approach is blind to how benefits are distributed among different people. Since CEA is distributively neutral, an allocation of health care resources may be unfair despite the decision is made in agreement with the fundamental principles of CEA. In other words, ethical concerns for fairness may lead to a violation of those principles (Nord 1999, Ubel 2000). Such ethical concerns will be discussed in the following sections.

Discrimination against People with Chronic Illness or Disability

Suppose Patient A has a preexisting chronic illness or disability while Patient B does not. There are two treatment programs with equal cost for treating Patients A and B, both suffering from a life-threatening illness.

Program 1 saves the life of Patient A but cannot restore him/her to perfect health. The patient will live with his/her preexisting health conditions.

Program 2 saves the life of Patient B and can restore him/her to full health.

The utility gained from Program 1 in saving the life of Patient A for one year is less than 1 QALY while the QALY gained from Program 2 is equal to 1. However, when people are asked to make a choice between the two programs, the most common view is that both patients should be equally deserving of life-saving treatments (Nord 1996a). Consequently, many people may consider it discriminatory if Patient B is given the priority to receive Program 2. However, this view seems to contradict the principle of maximization (P4) which implies that priority should be given to Program 2 because it produces higher utility gain.

Ethical Concerns for Severity

Many people seem to have special concerns for patients with severe illness. Suppose the QALY gains for treating Patients X and Y are the same but initial condition of X is more severe. Many people believe that, other things being equal, greater priority should be given to help Patient X. Principle P1 is therefore problematic under the circumstances in which the initial condition of the patient seems to matter. Even if the QALY gain of treating Patient X is considerably lesser than that of treating Patient Y, many people still believe that at least equal priority should be given to Patient X. This choice obviously contravenes the principle of maximization (P4).

In a study conducted by Erik Nord, a Norwegian health economist, the interval between death and perfect health was divided into 7 equal levels (Nord 1993b). His study showed that improving the health condition of severely ill patients by two levels was generally regarded as equivalent to a health improvement by three levels for moderately ill patients.

In another study conducted by Peter Ubel (Ubel 1999), subjects were asked to imagine that they had an equal chance of developing either Illness A or Illness B:

> Illness A: Seriously ill patients who can improve slightly with treatment.
>
> Illness B: Moderately ill patients who can improve significantly with treatment.

The cost of treatment for both illnesses is the same. Respondents were asked to choose between allocating more resources to treatments for either one of the illnesses and dividing the resources equally to both. The latter was the choice of many respondents.

The studies by Nord and Ubel showed a special concern for patients with severe illness. Such a concern implies that providing treatment for needy patients does have some priorities regardless of its cost effectiveness. For example, many people agree that HIV-infected patients should be offered drugs with uncertain effects. Given that health care resources are limited, there will be a trade-off between cost-effectiveness and the ethical concerns for the needy. Yet many people are in favor of meeting, at least to a certain extent, the need of the severely ill at the expense of compromising the goal of efficiency.

Give Everyone a Chance

Another ethical concern is reflected in many people believing that patients in the same conditions should be given the same priority of treatment irrespective of the size of treatment effect (Nord 1999). Suppose the initial states of Illnesses F and G are the same but the size of health improvement of treating patients with illness F measured in terms of QALY gain is less than that of treating patients with Illness G. It is not obvious that patients with Illness F should have a lower priority for treatment. Many people tend to believe that equally ill patients should have the same right to treatment irrespective of whether the treatment benefit is large or moderate. Yet the maximization of QALY implies that patients with Illness G should have higher priority.

A study conducted by Peter Ubel and his colleagues (Ubel et al 1996) provides further evidence that there is a concern for giving every patient of the same condition a chance for treatment. In the study, subjects were asked to make a choice between the following two tests for screening colon cancer in low risk people:

> Test 1 can be made available to all low risk people and save the lives of 1,000 individuals;
>
> Test 2 can only be made available to half of the low risk people and save the lives of 1,100 individuals.

The cost of both tests is equal and the government can only afford to offer one of the tests. It was found that many subjects preferred Test 1. This is obviously a violation of the principle of maximization (P4) since Test 2 can save the lives of 100 more individuals. Yet many subjects choose Test 1 for its greater availability.

Duration Problem and the Importance of Age

According to assumptions P1 and P3 of CEA, the utility gain of a treatment should be proportional to the duration of the benefit enjoyed by the patient, and the age of the patient, which is an initial condition, should not matter if it does not affect the utility gain. However, other things being equal, extending the life of a patient for twenty years does not appear to be as valuable as prolonging the lives of two patients for ten years. There seems to be a discount for future benefits (Nord 1999, Ubel 2000). P3 is therefore problematic. Furthermore, the age of the patient does seem to matter. For example, many people do not consider a life expectancy of twenty years for a 60-year-old person as valuable as extending the life of 10-year-old child for twenty years. Society may value treating the young more highly than treating the elderly because the fewer life years one has already had the greater right to enjoy additional life years (Nord 1999). This intuitive response shows that principle P1 is problematic with regard to age.

Cost-Effective Analysis : An Ethical Evaluation

Ethical Concerns for Higher-Cost Illness

According to CEA, other things being equal, treatments for higher-cost illnesses should have lower priorities. However, it seems unfair to discriminate against those who have higher-cost illness simply because a larger number of patients can get the same benefit at a lower cost. This shows that the value of an outcome is not always directly proportional to the number of people enjoying a particular benefit. For example, the cost of organ transplant for one single needy patient is high, yet many people will not accept using the money for transplant to fund a flu vaccination for a large number of potential patients instead although doing so in the end can save more than one individual's life. This example shows that both P2 and P4 (principle of maximization) are problematic.

The concern for higher-cost illness can explain one of the earlier failures in the Oregon Plan more than a decade ago. The state government wanted to extend the Medicaid program to cover all those who were below the poverty line. The extension was possible only if the limited budget was exclusively used to subsidize health care services of higher priority. CEA was the method adopted in the first attempt of priority-setting, which produced the highly unacceptable result that appendectomy was ranked lower than toothcapping, and office visits for thumb-sucking and low back pain (Haldorn 1991). The cause of this anomalous result was that the cost of appendectomy was higher than that of treating some minor illnesses. Effectiveness per cost ratio for appendectomy turned out to be lower, and so its priority was ranked lower than the treatments for some minor illness.

Ethical Concerns for Patients with Lower Chance of Successful Treatment

According to CEA, lower priority should be given to treatments with lower chance of success. Yet many people regard this as unfair. In a study conducted by Peter Ubel and George Loewenstein (Ubel and Loewenstein 1996a, 1996b), there were 100 usable livers to be allocated to the following two groups of patients who were waiting to undergo liver transplant:

Group 1: 100 children with a higher surviving rate of 80%;

Group 2: 100 children with a lower surviving rate of 70%.

Subjects were asked to decide how many livers should be allocated to each group of children. The above was one version of the simulated scenario. In other versions, the prognoses of the two groups were said to be 80% and 50%, 80% and 20%, 40% and 25%, 40% and 10%. Transplanting livers to the second group violates the principle of maximization, yet many respondents preferred an equal distribution. Even though quite a few respondents would prefer to give priorities to children with a higher surviving rate, many of them still believed that some children with a lower surviving rate should have a chance for liver transplant. Hence very few respondents followed the principle of maximization to allocate all the livers to the better prognostic group. This study showed that there was indeed a moral conflict between the principle of maximization and the concern for patients with lower chance of successful treatment.

Equity-weighted QALYs

CEA is distributively neutral because what matters for CEA is the unweighted sum of individual utility gains, so it is blind to how utility gains are distributed across different individuals. Yet the ethical concerns that we have examined show that a distribution of health care benefits can be unfair even though the aggregate benefits are maximal. To remedy the shortfall, CEA should focus not only on the utility gain but also its distribution. The outcome measurement of health care benefits therefore needs to incorporate the concerns for fairness. This does not imply that we have to abandon entirely the use of QALY or other similar units of utility measurement. One way to modify the outcome measurement is to capture the concerns for fairness by assigning equity-weights for severity, chance for improvement, duration and so on to utility gains measured in terms of QALY or other similar units of measurement. Equity-weight for severity (the so called 'severity weight') will be used as an example to illustrate the modification in the following discussion.

Severity Weight

Suppose we have worked out the following QALY gains per year for curing patients with life threatening, severe, considerable, and moderate problems.

	QALY Gain
(a) Moderate Problem	0.20
(b) Considerable Problem	0.55
(c) Severe Problem	0.80
(d) Life-threatening	1.00

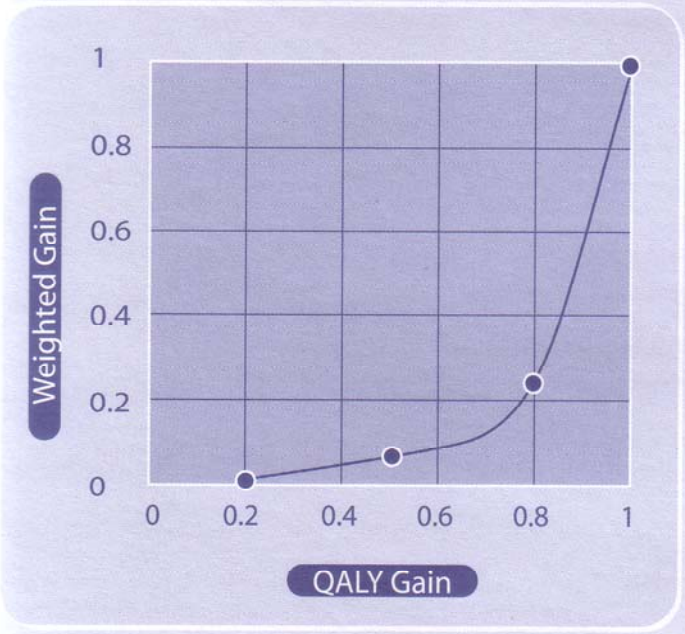
Source: Nord (1999), p. 75.

The person trade-off (PTO) method can be used to calibrate the weighted gains for patients in different conditions that reflect the ethical concerns for different degree of severity (Nord 1999, Ubel 2000). In applying the PTO method, people might be asked about how many patients have to be cured of moderate illness to be as equally important as curing one patient of severe illness. People might well be indifferent

between curing 25 patients who are moderately ill and curing 1 severely ill patient given the cost of treatment is the same in both cases because they are more concerned about the well being of the severely ill. Similarly, people might be indifferent between curing 100 patients with moderate problem and curing 1 patient with life-threatening illness. If the outcome of curing a life-threatening patient is 1, the weighted gains for curing the moderately ill will be 0.01 and the gains for the severely ill will be 0.25. Let's further suppose that people are indifferent between curing 8 patients who are moderately ill and curing 1 considerably ill patient given the cost of treatment is the same in both cases. The weighted gains for curing these four groups of patients by applying the PTO method may be presented as follows:

	Weighted gain	QALY Gain
(a) Moderate Problem	0.01	0.20
(b) Considerable Problem	0.08	0.55
(c) Severe Problem	0.25	0.80
(d) Life-threatening	1.00	1.00

Source: Nord (1999), p. 75.



The discrepancy between the two gains can be rectified by identifying a severity weight function SW which compresses the utility gain to the lower end of the scale:

Weighted Gain = SW(QALY Gain)

The SW function can then be used to determine the weighted value of QALY gains in conditions other than (a) – (d).

Cultural Considerations

Although there is strong evidence that people will try to strike a balance between utility gains and concerns for fairness, the extent to which the goal of efficiency is compromised can differ across different cultures. The equity-weight functions for severity, duration, and so on may therefore come in different shapes in different cultures.

This article has discussed three studies conducted by Peter Ubel and his colleagues (Ubel 1999; Ubel et at 1996; Ubel & Loewenstein 1996a, 1996b). The first two studies were conducted in Philadelphia and the last one was in Pittsburgh. My colleagues and I have replicated them in Hong Kong, Guangzhou, Shanghai and Beijing, with an aim to compare the ways in which the balance between utility gains and concerns for fairness is stroked by people in different Chinese and US cities.

As for the study in which subjects were asked to decide how the resources should be divided between treatments for seriously ill patients (Illness A) who can improve slightly and treatments for moderately ill patient (Illness B) who can improve significantly (Ubel 1999), the results were as follows:

People expressing preference for treating (%)

	N	Illness A	Illness B	Equal for A and B
Philadelphia	77	12%	13%	75%
Hong Kong*	281	17%	28%	53%
Guangzhou	800	19%	53%	28%
Shanghai	1050	35%	46%	19%
Beijing	1050	19%	57%	24%

** The total percentage is less than 100% because of missing data.*

Most subjects in Philadelphia chose to divide the resources equally between the two groups of patients. Although most subjects in Hong Kong made the same choice, the corresponding figure was lower. In addition, more subjects in Hong Kong gave priority to treatments for Illness B than treatments for Illness A while in Philadelphia the numbers of respondents opting for allocating more resources to treatments for Illness A and Illness B were almost the same. In the three other Chinese cities, most subjects preferred treating moderately ill patients (Illness B) who can improve significantly with treatment, though quite a number of subjects still chose to divide the resources equally between the two groups. Among the five cities, Philadelphia seemed to have the strongest concern for severity while the three cities in the Mainland China showed a weaker concern, and Hong Kong seemed to lie in the middle.

Cost-Effective Analysis : An Ethical Evaluation

As for the study in which subjects were asked to make a choice between Test 1 that can be made available to all and save 1,000 individuals' lives and Test 2 that can only be made available to half of the low risk people and save 1,100 individuals' lives (Ubel 1996 et al), the results were as follows:

% of respondents

	N	Test 1	Test 2	Refused to make a recommendation
Philadelphia	568	56	42	2
Hong Kong	281	44	55	1
Guangzhou*	800	39	60	0
Shanghai*	1050	33	63	5
Beijing	1050	44	54	2

**The total percentage is not equal to 100% because of rounding off.*

In Philadelphia, more subjects chose Test 1, but more respondents in Hong Kong and the three other Chinese cities chose Test 2. On the whole, the concern for giving everyone a chance in Hong Kong and the other Chinese cities seems weaker.

It is too complicated to report the detailed findings of the study where respondents were asked to allocate 100 usable subjects to two groups of 100 children with different surviving rates (Ubel & Loewenstein 1996a, 1996b). The overall picture is that the most popular choice in Pittsburgh was to divide the quota of liver transplants equally but the most popular choice in Hong Kong and the other Chinese cities was to give more livers to the group with higher surviving rates.

In sum, the above studies showed that public attitude in Philadelphia, Pittsburgh, Hong Kong and other Chinese cities were shaped by concerns of fairness. Nevertheless, the balance between cost-effectiveness and equity tended to tilt towards equity in Philadelphia and Pittsburgh but towards efficiency in Hong Kong and the other three Chinese cities.

Conclusion

A major shortfall of cost-effectiveness analysis (CEA) is its failure to take into account societal concerns for fairness. Such a shortfall has to be remedied by adopting a system of outcome measurement that can reflect societal concerns for fairness. As such concerns take different strength and shapes in different cultures, comparative studies are needed for the further development of outcome measurements that are suitable for different societies.

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Food For Thought!

In this issue of our newsletter, we will bring to you excerpt of articles relating to health services management. Being a busy manager, you may not have time to read, so we hope such synopsis will catch your attention and provide you with some food for thought!

Storytelling That Moves People

A Conversation with Screenwriting Coach Robert Mckee
(Harvard Business Review)

Forget about power- point and statistics. To involve people at the deepest level, you need stories. Hollywood's top writing consultant reveals the secrets of telling them in this interesting article from HBR.

The key to motivating people to reach certain goals is to engage their emotions and touch their hearts with a good story. In this article, Robert Mckee, the world's best known and most respected screen writing lecturer whose students have written, directed and produced hit films including *Forrest Gump, Gandhi. Erin Brochovich, The Purple Color etc.* talks of why he thinks we should learn to tell a good story!

Mckee explains that most organizations try to paint a rosy picture and sweep the dirty linen, the difficulties and their struggles under the carpet and they present to the world a boring and uninspiring story that often contains facts and figures. As a storyteller, we need to understand that our listeners are always skeptical and will hunt for the truth beneath the surface of life. Scratch the surface and you will only get luke warm response. A story that embraces darkness and told truthfully produces a positive energy in listeners.

Quotable quotes from this article:

> *"A great CEO is someone who has come to terms with his or her own mortality and as a result, has compassion for others. This compassion is expressed in stories."*

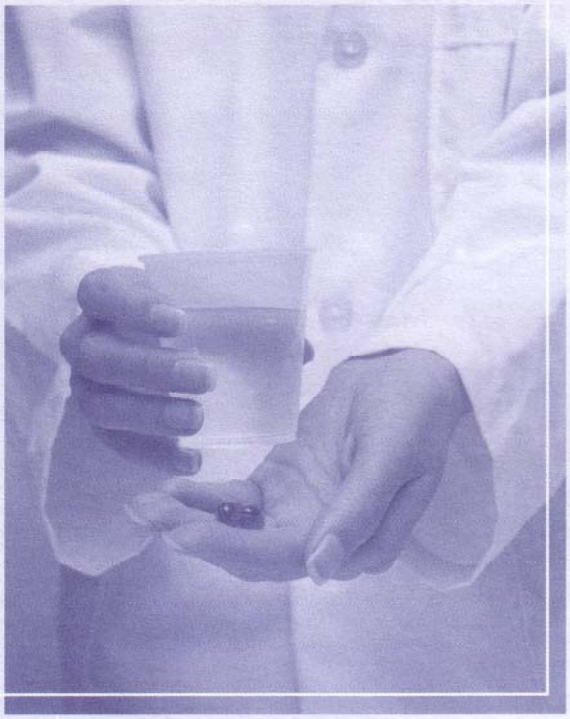
> *"Great storytellers – and I suspect, great leaders too – are skeptics who understand their own masks as well as the masks of life and this understanding makes them humble. They see the humanity in others and deal with them in a compassionate yet realistic way. That duality makes for a wonderful leader."*

Are you ready to get rid of those boring power point presentations and stand up there to tell a good story. Good luck!

Margaret Tay ■

From Hospital to Long Stay Care Home

The Ethics and Economics of the Transformation



Introduction

In the past few decades, in parallel with the closing of mental hospitals around the world, large numbers of severely mentally ill patients have been relocated to a variety of non-hospital residential settings. (1) In Hong Kong, one of the recent initiatives was to transform Lai Chi Kok Hospital, a 400-bed psychiatric hospital under the Hospital Authority into a Long Stay Care Home for chronic psychiatric patients. This move was necessary as there were over 900 chronic psychiatric patients waiting for long-term residential placements in the community and the average waiting time for a place in one of the few long stay care homes was around 7.6 years.

The new Long Stay Care Home, also known as HACare Home, began a 3-phase transfer arrangement in March 2001. About half of the original cohort of patients in Lai Chi Kok Hospital (180) remained in the Home and the other half (163) was transferred in from other psychiatric hospitals. Relatively fewer patients (49) were selected from the central waiting list for long stay care home and by end of February 2002, the HACare Home completed the admission process and was operating as a subvented Non-Governmental Organization (NGO) funded by the Social Welfare Department under the Funding and Service Agreement Scheme.

This paper will review the outcome of this project and discuss some of the ethical and economical standpoints from the perspectives of a health service manager.

Ethics and Morals of the transformation

A number of ethical and moral issues confront the health care manager as we make decisions that will ultimately affect resource allocation in health care. In the HACare Home project, we are confronted with similar ethical issues faced by health care manager everywhere. How can we assess the moral cost and benefit of the decision and ensure that patients' rights and autonomy be preserved? How can we be sure that by changing the model of care (from hospital-based care to a long stay care home), patients will be treated effectively and their confidence maintained. There are a number of essential ethical principles that should be brought to bear in any decisions affecting the financing and delivery of health care services and the following ethical principles are discussed here:

Autonomy

Autonomy represents a core individual right that encompasses the capacity for an individual to make decisions, change decisions and act on the basis on those decisions. (2) This is easily understood in the everyday context expressed as consumer choice or patients' choice. Can patients exercise autonomy in the decision of where they should reside? Do they have a choice as to whether the Hospital setting or the HACare Home setting is better for them and can they choose where they want to reside. In the context of the HACare Home project, those who were originally from Lai Chi Kok Hospital basically need not exercise their right to choose, as they did not have to face any change.

For those waiting for long stay care homes and staying in public hospitals, a choice had to be made and medical social workers in the hospitals assisted with patients in coming to terms with the decision. Hence, autonomy of the patients was preserved during the admission process. Once admitted to HACare Home, consideration was given by the management to transform the setting of the Home to a more homely and less restricted environment than the previous hospital setting. The number of restrictive practices in the Home was reduced from 43 to 40. One may argue that this slight reduction is not adequate to make the hospital into a Home. However, given that the reduction in number of restrictive practices was limited by operational constraints and fraught with difficulties, there are certainly limits in which full individual rights can be exercised and notably with mentally ill patients, boundaries must be set which would sometimes compromise individual rights for the sake of the public good. For instance, it would not be desirable to allow male residents into the dormitories of female residents nor would it be safe to permit residents to smoke in the dormitories.

Beneficence

Beneficence is a broad term encompassing the notions of virtue and duty that requires individuals and institutions to pursue beneficial goals and positively shift the balance of good over harm. (2) To bestow more good than harm is an essential and important ethical principle and services should be provided to do good for the client. Did the HACare Home pursue this principle diligently? All in all, most of the residents in the Home enjoyed a good level of care. This is evident from the quality of life scores of the residents at the beginning of the project and at the third year of the project, when they were re-assessed with the same Quality of Life questionnaire.

During the course of the 3 years, residents were also assessed on their functioning level. Level 1 represents the lowest level of functioning and level 5 represents the highest level of functioning. In 2001, 73.6% of the residents were assessed as functioning at level 1 and by March 2003, when the second assessment was conducted, 43.5% were assessed as functioning at level 1 and by March 2004, the number of residents functioning at level 1 decreased to 19.8%. The improvement in functioning level and the generally good rating of quality of life score are soft evidence that the organization bestowed more good than harm to the residents

Non-maleficence

The principle of non-maleficiene is closely related to beneficence, extorting decision makers not to impose harm or evil upon those affected by their decisions (2). Did the transformation of Lai Chi Kok Hospital adhere to this principle of non-maleficence? During the course of the project, 8 residents passed away (due to physical illness), 8 were transferred to old aged homes as they were suffering from various physical ailments and could be better cared for in aged homes, 6 were rehabilitated to a sufficiently high level to be discharged to other residential settings, 2 deteriorated in their mental condition and re-admitted to psychiatric hospital, 1 absconded from the Home and subsequently re-admitted to another psychiatric hospital and 1 went missing and subsequently committed suicide.

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As compared to those who stayed in the hospital, these results are not worst off, and in fact, they could be better than the outcomes in our psychiatric hospitals. Although it may not be prudent to conclude that the transformation did more good than harm, it is also justified to claim that the transformation did not in any way, do harm to the residents.

Next, the Economics

Just as there are ethical principles, health care economics should be applied in the analysis of health care decisions. Some of the common principles discussed in health care economics are:

Concept of Scarcity

In the face of scarcity of resources, there is a realization that some programmes must give way. In the hospital setting, nurses and allied health professionals form the backbone of the treatment team providing high quality care to patients. When resources are scare, the limited manpower should be targeted to those that can benefit from their expertise and by diverting chronic patients to long stay care homes, the expertise of valuable professionals can be devoted to those who have more potential to resume their life roles in society. The transformation of Lai Chi Kok Hospital into a long stay care home provides the opportunity for health care professionals to concentrate on the more acute cases in the hospital and the so called shifting of care to less well trained staff in the Home setting can provide opportunities for cost containment and cost savings.

Opportunity Cost

When chronic patients remain in the hospital and clog up hospital beds, the opportunity cost is the probably the cost of provision of acute psychiatric services and out-reach services. By freeing up resources from chronic long stay patients who do not require hospitalization, more services could be provided to other patients with higher priority of needs.

Efficiency

The cost of operating a non-acute psychiatric bed is estimated at about HK$900 per bed day. By changing the model of care delivery in the Long Stay Care Home and using a different staff mix, the cost per bed day of HACare Home is estimated to be about HK$250 per bed day. The inputs required to produce the same set of outputs and outcomes in the HACare Home are reduced considerably and it is at this level that we can establish that the Home is technically operating at an efficient level and the transformation programme a worthwhile pursuit.

Wealth Maximization

Health care is not an end in itself but rather an intermediate good that contributes to the production of good health of the community and ultimately maximizes the wealth of the society as a whole. By running the HACare Home in an efficient manner, the chronically ill who are unable to look after themselves are housed and care for in a safe environment. This in turn, protects other members of the community from harm and contributes to a safe and healthy community as a whole.

Conclusion

By using ethical and economical considerations to guide our evaluation of the transformation project, there is reason to believe that scarce resources are being utilized in the most efficient manner without compromising the morals and ethics of care. This explicitness in setting out the objectives and priorities of care will foster a better understanding of the relevance of ethical considerations in mental health policy and end the debate surrounding the issue that health care policies are solely influenced by economics.

Just as J Miles said in his keynote address presented at the Australian Health Summit 2003 : " Here then is the message from ethics: a call for action rather than as an appeal to theory. It's time to look at the society in which we live and to ask ourselves: Is this a society in which there is real justice? Is this a society where I and my loved ones, in our time of trouble, can be sure to access care which is compassionate and thoughtful?"

I hope that as health service executives who apply both ethical and economical realism to problem solving, we can create a better society for everyone, especially the silent forgotten minority who live in a world of their own.

Margaret Tay ■

References:

1. De Girolamo, Giovanni; Bassi, Mariano, *Residential facilities as the new scenario of long term psychiatric care,* Current Opinion in Psychiatry, July 2004
2. D Chisholm, A Stewart, *Economics and Ethics in Mental health care, Traditions and Trade Offs,* The Journal of Mental Health Policy and Economics, 1998.
3. J Miles Little, *Money, Morals and the Conquest of Morality,* Health Manager, Summer 2003.

Coming Up

Health and Beauty

If you are keen to know more about health and beauty, look out for the coming talk on this subject by Dr Gordon Chiu, a US skin expert. There will be a talk and demonstration on how to look youthful and prevent that dreaded ageing process from happening too quickly. The tentative dates are 11/1/2005 or 12/1/2005, subject to the availability of the speaker!

Health Care Management Course in Zhejiang, China

This course was originally scheduled for October 2004 but we now intend to hold the course in March 2005 instead. For details of the programme, please refer to the poster below:

香港衛生護理專業人員協會　香港醫務行政學會　浙江大學

醫務行政研修班 - 國內醫務管理發展，前景及機遇

日期： 2005年3月25 – 4 月1日　　地址： 浙江大學

本研修班由 香港衛生護理專業人員協會、香港醫務行政學會、浙江大學 聯合舉辦。由全國位列第三的浙江大學統籌及邀請國內專家作各課題的講者，各學員必定能夠從中得以更了解國內醫務管理的最新發展及機遇，加強香港及國內的合作。

主要內容及講者：

1. 國內醫療衛生發展及前景
   蔡仁華 – 國家衛生部原政策法規司司長，現中國衛生經濟研究所所長
2. 國內醫療市場、醫療融資，包括企業參與安排及投資等
   裘華生 – 民營浙江廣福醫院院長
3. 國內公共衛生政策、社區醫療
   李魯 – 浙江大學社會醫學研究所所長
4. 國內醫療管理改革，包括醫療架構、專業註冊認可、專業保險等
   王楨 – 浙江省衛生廳醫政處
5. 中、西醫結合應用
   鄔成霖 – 杭州市中醫院副院長，浙江中醫院教授

名 額： 40名，額滿即止

團 費： 每人港幣約$ 5,300元 (費用包括來回機票，食宿，交通，景點門票，及研修等費用。)

報名截止日期：2005年1月31日

注： 1. 授課語言：普通話
2. 修畢以上課程，舉辦機構將聯合頒發結業證書。

歡迎查詢，敬請致電秘書處莊小姐：3106 3395。

Application Form

Hong Kong Society of Health Service Executives

Membership Application / Renewal Form 2004/05

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