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Fragments: Managing Care in Europe

Fragment1: Healthcare in policy – Priorities, installation and implementation

At the time of writing, September 2004, commentators on the American presidential election predict that the winning candidate will be he who best engages the electorate on the three "big themes" of war, the economy and healthcare. In Britain, Prime Minister Tony Blair prepares for the UK General Election in 2005. He emphasises the UK's role in the "new war" in Iraq, and is occupied with the peace process in Northern Ireland. He meets Trade Union leaders, and seeks to reassure them about his focus on improving employment conditions for working people. All political parties seek to woo the electorate with their programme for improvements in health and education.

Although these examples are taken from the not-Europe of the USA and the maybe-Europe of the UK, they illustrate the fact that health always takes its place as a key policy issue at election time and –sometimes – throughout any government's term of office. However, having determined the character of a health policy, governments have to ensure that it becomes installed as a priority for appropriate agencies; this usually involves finance, and decisions as to the best method of funding. (In England, a preference for general taxation as a funding mechanism over – say - co-operation with insurance companies is an important marker of political orientation.) Furthermore, once a policy has been established as a priority through incentives and directives, it must be embedded into the working practices of responsible healthcare organisations. The practical implementation of policy – especially when involving changes or innovation – is always very variable in a system of any size. Governments throughout Europe frequently fail to understand the immense distance between the articulation of policy as a rhetorical act and its realisation in practice. In consequence, they become frustrated and disheartened, often seeking greater control or introducing new policy directives.

Fragment 2: Ideas about Europe

It has become banal to observe that healthcare is delivered in different countries in Europe in very different systems, and that – although similarities can be discerned – it is pointless or a waste of time to think about something as big and varied as "European healthcare". However, it can also be asserted that the future of healthcare for Europeans will both reflect and influence the future of "Europe" itself. The healthcare that emerges in practice will reveal the way that Europe conceives of itself, and how the constituent states think about their relations with others outside their own borders, or outside Europe itself.

Healthcare is a crucial component in the electability of political parties, and is in consequence a defining token in the relationship between government and governed. Governments, however, take policy decisions against the uneasy backdrop of a world economy in which control over key resources is contested so actively and violently that the very survival of some nation states is uncertain. Within Europe itself, there is a constant danger that extreme views and practices will so polarise the relationship between groups of citizens or between the state and some citizens that access to health and social care benefits become the currency of processes of exclusion or repression. We should not be complacent that the "Europe" that emerges will manifest be one that recognises the contribution in culture, energy and skills that all people bring – whether they come from inside the boundaries of Europe or not. The noble vision of Europe, powerful yet compassionate, will never be achieved once and for all, but only through repeated and sustained effort.

Fragment 3: Tensions and problems

It has become customary to view healthcare provision as problematic, and in need of development and reform. For the last decade at least, the following three imperatives or areas of constraint have been represented as being in tension and as sources of difficulty.

- Demographic change – by which is indicated firstly the growing number of elderly people with complex health needs, and secondly the decreasing number, relative to the number of elderly "health resource users", of young, employed people capable of contributing to a nation's GDP.
- Technological development – by which is indicated the increasing range and sophistication of, for example, surgical and pharmaceutical interventions which make previously untreatable conditions treatable. Such interventions may be expensive, and their unanticipated availability (and desirability) can have a substantial impact on a system's financial sustainability.
- Healthcare users' (or citizens' or consumers') rising expectations – by which is indicated on the one hand people's wish for speedy access to all kinds of general or specialist care, for levels of information and of involvement in the processes of their own care that were unthought-of of a generation ago, and on the other, a tendency to regard the provision and receipt of healthcare as having much in common with other forms of consumption, and therefore being subject to the same kind of legal redress in the event of dissatisfaction or perceived failure.

Long-term shifts in the practice of government as well as these imperatives have meant that governments throughout Europe have been willing to countenance the political cost of limits or even reductions in expenditure on health and social security benefits. The impact of such changes has been widespread and complex, and one such has been the unexpected diminution in the prestige of medicine as a career and the consequent difficulties in recruiting appropriate candidates (however defined) to become doctors. Many vacancies already exist for medical practitioners, particularly in rural areas, and this trend of shortages is likely to accelerate. Existing doctors have had to confront

challenges to their historical domination of certain fields of activity (for example, by nurses), and many have chosen to reduce their availability to members of the public (for example by reducing their commitment to out-of-hours service provision).

All participants know that healthcare is much more than the work of doctors, but their claim to domination of the field over the last century has been quite effective in ensuring general acceptance of their claims to uniquely superior knowledge and competence. Governments and other funders run the risk of frustrating users' expectations when they attempt to mitigate the effect of rising costs and recruitment difficulties through the introduction of new practices involving other health workers.

Fragment 4: Managing Care

Managed Care means many things. In this as in other matters, the nation states of Europe are characterised by diversity and variability in quality and quantity. Healthcare is however universally significant in the relationship between government and people, and therefore susceptible to manipulation and interference. Some attempt to ensure a proper and explicit linkage between individual and collective needs and desires for the content, form and style of healthcare on the one hand, and the configuration of services actually made available on the other, is a sign of a civilised society. It is also a sign of a managed care system. Such an explicit linkage does not necessarily imply a state run model of care, typified by the British National Health Service, but it does imply *management*.

Management can have many manifestations, some highly contentious in a healthcare setting. There is little disagreement, however, that if they are to exist at all, healthcare managers should be *effective*. To this end, and if they are to avoid the tyranny of "common sense" and the unquestioned promulgation of the status quo, they should embody in their practice the best available descriptions and models of human interaction. This is indispensable when powerful members of organisations seek to promote or undermine co-operation in the name of the common good, multidisciplinarity or personal and professional freedom or self-interest.

Healthcare managers also need to be effective *ethically*. As they seek to navigate a path between shifts in government policy and developments in public expectation, and as they implement tricky decisions about the allocation of resources, managers need to act properly as well as effectively. The moral person (and manager) is not one who acts with inflexible certainty, but one who constantly struggles to find a path between the demands of competing goods. To enact their role properly, healthcare managers need to pay as much attention to moral philosophy as they do to economics or sociology.

Fragment 5: Reform Management

Throughout Europe, contemporary configurations of healthcare services are likely to be criticised by users for the difficulty in accessing specialist services in a timely and

affordable fashion, or for the lack of co-ordination and integration between different agencies or organisational subsystems. Not all governments in Europe aspire to supply healthcare to their citizens through direct taxation, but all lay some claim to ensuring that a socially just and high quality system of healthcare is available. For many, there is a requirement simultaneously to bring spiralling costs under control and yet to provide services that better match the aspirations and expectations of citizens. In a word, there is a requirement for *reform* in health and social care systems.

“Managed care” can be understood as a vehicle for reform, in that it represents a working through of competing policy priorities, and as a search for the resolution of tensions between opposing practices of expertise and citizenship. As such, it has an appeal to funders, and can be portrayed positively to service users. However, while few health professionals really resist innovation and reform that is plausibly to the benefit of “patients”, yet anything that smacks of curtailment of professional autonomy (such as prior decisions as to the allocation of resources, for example, or protocols devised under the sign of multidisciplinarity) is regarded as deeply suspect. In such circumstances, the probity of managers, and their ability clearly to articulate the logic of their practices is of paramount importance.

It is our vulnerability and susceptibility to episodes of difficulty and ill health that defines us and links as human beings, not our robust independence at times of rude good health. It is the bravery to question established interests and practices, and the resilience to doggedly pursue an enquiring path that defines the good healthcare manager, not the inflexible defence of a predetermined position.

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