EDITORIAL

THE MODEL ILLUSION IN HEALTH CARE

Human imagination is usually somewhat constrained in the management of everyday affairs, so that relatively few administrative systems reflect a continuing spark of originality, being by nature relatively conservative in most cultures. Rather than innovate locally, structural organization tends to utilize transfer of ideas from one place or country to another, perhaps too easily. Health care systems are no exception. Partly these have grown up over historical time, piecemeal, as amalgamations of rules, regulations and relationships that reflect additions or subtractions, as each generation of bureaucrats succeeds the one before, with occasional interest thrown in from the political arena. From time to time a transient visionary steps into ill-fitting shoes, puts forward grand vistas of sweeping change, which gradually succumb to the inevitability of inertia. Even more rarely such a visionary manages to implement part of the grand scheme, but almost never does she last long enough to see the scheme flourish and pass the test of success in the long term.

Others, ground down by the everyday burdens of office, from time to time glance around, to lands beyond their shores, in hope that borrowing ideas will save the effort and the struggle of initiation, and perhaps bring a little reflected glory into the bargain. The *model* becomes the center of debate, the model already "tested" elsewhere is an easier option which allows acceptance by virtue of the accumulated evidence, even though that is based on the experience of others in other cultures, other economies. The problem, of course, is that the details of local experience on which the model is built are non-transferable, so that transferred models sit on untried, potentially shaky ground. This is as true of health systems as of any other human endeavor.

The systems search

The pilgrimage to a utopia of health care reform is underway around the world. Why is this so? Apparently golden examples, such as that of Sweden, which exhibited reasonable degrees of efficiency, efficicacy, effectiveness and equity, the idealistic *four Es* of economic theory, gradually and grudgingly found themselves unable to pay their way, as their very success decreased infant mortality and raised life expectancy. This led in turn to a dramatic change in the population age pyramid, with a burgeoning bunch in the older age groups who then generated more chronic illness in the post-employment generation. Western eyes looked westward, to Britain with it self-lauded but rusty national health service, to the US with its high tech solution on a grossly inequitable base of super expensive incompetence, to Australia with its tax-based sliding scale of compulsory insurance, riddled with padded ovecharging but relatively equitable public/private mix, and to many other experiments in health care financing.

Few if any western nations looked eastward to Japan, which has the world's best health indices, served by a health system which is 90% private sector based. Few looked at Singapore with its costly but equitable public/private mix in a tightly controlled, economically successful political system. Whether these examples will weather the long term challenges is uncertain. Most rich nations face the aging population cluster at the top and even those not yet so rich are moving in the same direction.

For poor nations these models *in toto* seem distantly unattainable, whatever their positive attributes. Nevertheless many nations look to these models for hope and guidance in organizing their health systems. A common thread is the preoccupation with hospitals and with training costs heavly weighted towards the manpower needed to staff those hospitals. Superimposed upon that model are various mechanisms which recognize that quality hospitals are often not readily accessible to many segments of rural populations, who at best receive care in the form of health centers or village clinics staffed with less well trained personnel. However many people bypass these centers, heading at considerable cost, direct and indirect, for the hospitals which ostensibly have greater expertise, so to participate in the core pillars of western models.

Money myths

The models stemming from London, Boston, Baltimore, Paris, Toronto or other meccas of perveived

excellence exert their influence in several ways. First, many health personnel receive training at such "meccas" and carry the pearls of supposed wisdom back home with their diplomas. Second, many health ministries seek consultants from the earlier alma matas of their upper crust, to reinforce their transferred lessons and these consultants obligingly carry out their ill-conceived tasks. Third, the upper crust from governments often seek their own medical treatments from the same western centers rather than relying on local transferred expertise. The combination is, in practice, very powerful in its influence.

Allocation of budgetary funds in the public sector for health services often reflects the high tech trends of the western models as a result of this potpourri of influence. Curative care receives the major share, personnel training is geared towards perpetuation of this bias. The consultants come, laud the developments that most closely reflect the western models, overlay their advice with perceived but seldom tried wisdom about the place of preventive care and return to their home bastions where their advice fails to modulate their own national health care structural disasters: the US for example sports perhaps the world's most *cost ineffective* health care system, yet it proudly exports its unwisdom and many try to emulate aspects of a system that academia in that nation has failed to rescue. In part it may be argued that it is the very preeminence of USA in science that has helped to spawn an inappropriate approach to health systems operations, by virtue of excessive reliance on the hi-tech medicine that has evolved in the extraordinarily creative American environment. That, of course, is only part of the real story. But our concern here is the inappropriateness of that model of health care.

The banks lend their money, hospitals proliferate and trained health personnel cluster around the city centers. The money myths grow in stature, hi-tech predominates and rural populations continue to receive second rate service. Even a cursory glance at the statistics (World Development Report, 1993) shows that a small but crucial number of poorer countries such as China, Costa Rica, Sri Lanka have comparatively good health indices which have been achieved despite low gross domestic products. Money alone clearly does not guarantee good health care, nor does lack of money necessarily lead to poor health care. There are of course monetary limits below which that maxim cannot hold, but the money myths are leaky at both ends. Structure, political will, disciplined community participation are more important. Those who have these and also have money, like Sweden, Switzerland and Japan have done exceptionally well, but those models are not so common.

Disease dilemmas

For reasons that are not too clear, talking about health care systems sometimes appears to be a separate subject to discussion of specific disease control programs. Perhaps it may be argued that many of the latter have come to be managed by enclaves within health ministries, enclaves that have developed their own cultures, with their own budgets, their own decision making formats, their own civil service substructure. The debate about vertical versus horizontal programs is an old one, yet it smoulders on. There is little doubt that vertical programs serve a valuable purpose for a particular time period and that merger with the broader health system tends to lose much of the zeal necessary to attack a specifically tough disease problem. But rarely in the past has a disease-specific program deliberately planned ahead in terms of finite time frame the transition from separate existence to integrated merger. In recent years in many countries this transition has been forced by dint of budgetary constraints; in the arena of infectious diseases these have often become administratively grouped under a Department of Control of Communicable Diseases or its equivalent. Non-communicable diseases tend to be more scattered for historical reasons.

Whatever the administrative structure into which they fit, specific disease control programs, like the larger health systems of which they are part, have often been formulated by reference to distant models, mostly western in concept. Thus malaria programs have taken on an image fostered by WHO, under the initial directives of former colonial administrators, adapting from one acronym to another, over a range from eradication to control. Spraying of insecticides continues to take much of the program budget, even past the point when most vectors may be exophilic and exophagic in certain geographic subregions. Why? The personnel in the program have been inducted into the spraying culture and are often reluctant to explore other cultures. The process itself can be seen as overt evidence that government distantly "cares" for the rural poor, so it stores up political capital for that occasional election day. The models are taken up and perpetuated for the wrong reasons. AIDS, to take anther example, has had more than a lion's share of many national health budgets,

often beyond reasonable equity, partly because of its prominence as a "political" disease. The western models again impose their patterns, often without differing national priorities being seen in appropriate perspective. The same has been true for a number of other disease-specific programs.

Emerging rationality?

Not all nations have blindly followed western models. Many have adapted these to local needs, some have started from scratch to develop new ones. Factors limiting such initiatives are often the policies of external funding sources, multilateral or bilateral. Intended benevolence becomes constrained by models familiar to the donor, rarely is there wisdom enough or trust enough to make funding available for entirely locally based planning, without external consultants to limit the variations. Much as the mulilateral lending agencies are often targetted for criticism, bilateral funding frequently exhibits greater paternalism, because of the desire to wave the flag of a donor nation and to give its "experts" a taste of planning power. Thus money is made available for educational or operational programs with the proviso that the donor nation set the curricula or approve the operations in detail, even though the recipients may have already shown much greater capability than have the donor nations for effective management of small budgets using appropriate technology. Tied money thus results in acceptance of the donors's models, not of the more appropriate ones that are or could be locally generated. Ultimately this results not only in wasted money but in ineffective systems.

However, there are signs that some poorer nations have the courage to develop rational models of their own rather than submit to imposed or imported ones. One reason may be the relative failure of western health care models to endure in the long term. In this sense many nations, rich and poor, are back to the drawing boards to reform their health systems, searching for a mechanism to enhance equity, the most elusive element of the economic quartet. The inclusion of disease-specific programs is part of the agenda. So too is emphasis on prevention, although with non-communicable diseases the debates will continue to be long and labored: evaluation of screening technology needs more emphasis on cost-effectiveness.

Another part of the stage play portraying the search for better health systems design is the issue of public/private mix and the cost-sharing dillemma. There is a reservoir of good-hearted public health leadership that abhors the concept of a user charge for many disease-specific programs where these are seen as *public goods*, which should be paid for out of tax revenue. At the same time, objective surveys often demonstrate the willingness to seek private sector treatment before going to the public health center, suggesting that some degree of cost-sharing may be more widely acceptable than is currently envisaged. It is unwise to arrive at hasty conclusions in the public-private sector debate without thorough socio-economic research. However, in many countries this debate is accelerating in urgency and importance, as human resources are lured by hard cash from public to private health care enterprise, leaving the public arena bare of essential personnel.

Thus center stage in public health is now occupied by the widening spectre of the multi-faceted search for affordable, efficacious, efficient, effective and equitable health care systems, regardless of the total money in the economy of each nation. Perhaps the key lesson of the model transfers is that most from the past are non-transferable from one economic culture to another at any particular point in time. All must do their own homework and their own drafting, and they must have the strength to convince the international funders that this is paramount to the evolution of viable systems.

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