Preface

NORMAN SARTORIUS

At least three questions seem to beset the health care systems of the world today: first, how much money are we spending on health care; second, could we get as much or more effect for less money; and third, who should be paying for health care?

The first of these questions seems, at first glance, to depend on good accounting. Information systems could, whenever and wherever they function, provide information about the amounts spent for health care. The second question also seems to have a simple answer: by pooling results of research and experience we should be able to devise structures and strategies that will allow us to get maximum benefit from our investments into health care. The third question appears to be a matter of reaching an agreement about the distribution of responsibility, and is therefore no more than a case of applying the principles of a government to a specific problem.

Unfortunately, things are less simple. In addition to human problems that arise whenever tasks, power and resources are distributed, there are a number of epistemological difficulties that have to be resolved as well. It is not possible to enumerate all of them here: a few will suffice to illustrate the difficulties that have yet to be overcome.

While it is, for example, relatively easy to record all the expenses that a system has, it is often difficult to decide which expenses concern health care because there are at present very few examples of good translations of a definition of health into an accounting system. There are significant differences among the definitions of health and disease produced by specialists in the same branch of medicine and even greater differences among definitions produced by specialists belonging to different disciplines. Health care organisations also vary in their definitions of health. As long as it is unclear what the limit of good health is, it is difficult to know whether a particular expense was related to the treatment of a disease, to the improvement of health, to the improvement of quality of life or simply to the kindness of the treating physician. The point of disappearance of disease for which the treatment has been prescribed is also rarely well defined. Although this task is relatively simple in the instance of some communicable diseases with a well-defined beginning and end, the decision about the end of an episode of psychiatric illness or about the point at which arterial hypertension has become compensated is more complex and, therefore, makes the assignment of costs for treatment more cumbersome.

The differences of opinion about the limits of disease present a serious obstacle to the evaluation of cost for care and of the benefits derived from investment into health care. This difficulty is further compounded by differences of opinion about the desirable quality and quantity of care. At present there is little agreement about the minimum, optimum and (excessive) maximum of care for a particular patient, disease or population group. Health care is being organised to fit the amount of resources that are made available to the health care system: this leads to curious decisions, goals and differences among services. The provision of health care for certain types of illness through a system of primary health care workers is considered possible and desirable in many countries with few resources: why is this system not equally good for countries that are rich? The diseases that are being treated seem to be same, the people are the same or very similar and the effectiveness of treatments does not show many differences either: why is it, then, that the health care workers in the poorer countries do not seek parity in terms of resource allocation? It is not enough to say that the care provided is the best possible under the economic circumstances: the best care is clearly the same and it would therefore be important to ask for the same amount and type of resources for dealing with a disease regardless of the standing of the health budget – even if, at the time, it would be impossible to provide all that is necessary.

A third example of problems that arise in answering the questions stated above is that of accounting for the amount of effort that patients themselves and their families invest into their health care and treatment of their diseases. This amount can be calculated differently and depends on value systems in a community just as much as on the possibilities of finding paid employment for those who are ill or for members of their families. The ways of measuring the indirect costs of diseases are at present unsatisfactory and the various indicators that have been proposed to do this have met with limited acceptance by economists, health workers and the political system.

There is no way that these and many other problems surrounding the measurement of costs, benefits, efficiency and effectiveness can be resolved quickly, and there is little doubt about the fact the best way forward is an accumulation of insights from practice and research examined in a spirit of constructive debate about the best strategies and tactics in this difficult field. The papers presented in this supplement are an important contribution to this discussion and I feel honoured by the opportunity to write this preface.

NORMAN SARTORIUS, FRCPsych, Dept de Psychiatrie, HUG, 16–18 Bd St George, 1205 Genève, Switzerland

https://doi.org/10.1192/S0007125000297973 Published online by Cambridge University Press