Chapter 17

Managing paradox

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Trade-offs in health reform

In the last three decades, health systems in the European region have gone through a number of major reforms in pursuit of a range of objectives. Since the early 1990s the emphasis of many of these reforms has been on achieving financial sustainability, improving quality and social responsiveness, whilst at the same time maintaining equity and access, which are seen as central tenets of Europe's health systems. Many commentators have argued that these objectives are not complementary, that often they stand in direct contradiction to one another. They identify the need to make explicit trade-offs between them, and assert that these trade-offs should reflect societal values and the relative priority assigned to them.

This chapter starts with the observation that policy makers routinely make trade-offs. With particular focus on the countries of Western Europe, it looks at the nature of the trade-offs between the various objectives of health system reform, implicit and explicit, and explores the salient trends and developments in handling them. The first section seeks to clarify what is understood by health system objectives, and discusses the role of values and ideology in determining their relative importance. Three sections follow, addressing what have been hailed as three main trade-offs for policy makers: between financial sustainability and equity; between responsiveness and equity; and between responsiveness and sustainability. The final section will summarise the main lessons from the review of these three trade-offs, and suggests an approach to managing them.

Health system goals, values and trade-offs

In attempting to assess the trade-offs between different health system objectives we need first to define what these objectives are. This is far from straightforward. There is an ongoing debate about how to define them, and about how to formulate and quantify them. Different policy documents put forward a range of objectives that includes 'health gain', 'improved health outcomes', 'cost containment', 'equity', 'allocative and technical efficiency', 'consumer satisfaction', 'equity', 'access', 'choice', 'quality', 'transparency', 'accountability', 'citizen participation' and 'provider satisfaction', with different priority given to each, and different combinations advocated.

These objectives may all be important but they are not always consistent with one another, nor are they comparable. They exist on different levels – the philosophical, the technical and the operational. They overlap each other and

are often difficult to measure. If we are to assign relative values and priorities to them we need a clear and concise framework of objectives.

In this field, a key contribution of WHO's World Health Report 2000 is its definition of health system boundaries. A set of what are termed primary health system goals is postulated: 'improving health', 'enhancing responsiveness to the legitimate expectations of the population' and 'assuring fairness of financial contribution'.[1] The Report argues that all other policy objectives will ultimately affect and feed into these three main goals. Here we suggest a slight adaptation of this approach and propose the following:

- **Health improvement:** The *raison d'être* of the health system and so its primary or defining goal.
- **Responsiveness:** Meeting the population's legitimate expectations and generating satisfaction. This is an important objective in itself, and goes beyond specific health improvements that result from therapeutic intervention. Responsiveness is defined as embodying two major categories, each further subdivided into four domains: *respect for persons*, which includes regard for dignity, confidentiality, communication and autonomy; and *client orientation* which consists of prompt attention, adequate quality amenities, access to social support networks, and choice of institution and care provider.[2]
- **Equity:** The distribution of health and social responsiveness in the population; includes the notions of fairness of financial contribution, and of access, utilisation and treatment according to need.
- **Efficiency:** Both technical efficiency (achieving 'value for money' by minimising costs or maximising outcomes) and allocative efficiency (allocating resources between sectors to maximise overall health levels from within existing resources).
- **Financial sustainability:** An extension of the notion of macroeconomic efficiency to ensure that the appropriate share of society's resources is used. It can be defined simply as the ability of the system to generate sufficient (and sufficiently reliable) resources to allow for the continuing (and improving) provision of healthcare for a growing population, despite increasing costs. It also addresses the need to ensure that the share of society's resources devoted to health is appropriate, and that the demands of meeting present needs do not compromise society's ability to meet future needs.[3] An important implication is the achievement of better value for money in the light of constraints in public financing.

The selection and formulation of the above objectives is by no means universally accepted. There are many debates both about the hierarchy of objectives and about their precise boundaries. There is discussion, for instance, about whether 'quality' constitutes an objective in itself or an intermediate objective, contributing either to the achievement of 'social responsiveness', or to the attainment of the overarching goal of 'health improvement' (a view to which we subscribe). Similarly, 'financial sustainability' is closely linked to 'efficiency', although here, given its importance in policy making, it is singled out as a separate objective. On the whole, however, the above set serves to capture the main objectives of the health system.

Interestingly, these objectives, and the underlying concerns for which they are markers, seem to be shared by diverse health systems in very different countries.

A review of various national policy documents addressing the objectives of health system reforms reveals a striking convergence between them. In practice, however, these national reforms pursue quite different priorities and achieve quite different trade-offs between their objectives.

There seems to be a real reluctance openly to admit and discuss the potential conflicts embedded in the priorities and objectives that are set. It is often very difficult for policy makers, in whatever setting they operate, to be seen to argue that any one of the (very laudable) health system objectives is less or more important than any other: for example, that 'social responsiveness' should be sacrificed in the interests of 'efficiency'. There is a tendency therefore to obscure conflicts, and often the trade-offs, however necessary, are not made explicit. It can be argued that at the outset of any reform process, to keep the precise set of objectives ambiguous, and the possible trade-offs implicit rather than explicit, may avert potentially damaging debate. This ambiguity may allow the creation of a momentum towards reform, and accelerate its implementation. However, in the long run, as the real priorities attached to different policy objectives become apparent, a failure to make explicit the choices that policy makers have to make will be interpreted as excluding the public from the debate, and may thus generate opposition that can undermine and often reverse reform.

Another obstacle to progress is that when the necessary debate on values and trade-offs does take place, it focuses too often on the means and the policy instruments to be applied, rather than on the ends or the objectives of the health system. Moves to introduce elements of privatisation in European health systems serve as a case in point. Often privatisation becomes an end in itself – an ideological goal rather than a means to an end. There is a need to disentangle the evidence on the impact of privatisation on objectives such as responsiveness, efficiency or equity from the values assigned to these objectives by particular social cultures and political philosophies.

Disentangling these elements calls for a clear framework of objectives and demands priority-setting that reflects societal values. Making trade-offs explicit is central to this. An open debate about trade-offs provides for shared ownership of reform and the validation of the choices that policy makers must make, allowing citizens to balance evidence, ideology, culture and policy-judgement. It is also central to the assessment of the impact of reform strategies against goals that have been weighted according to societal values.

This chapter seeks to contribute to that debate by exploring the nature of a number of trade-offs between health system objectives. We focus on three of them, not only because the trade-offs between these three are particularly complex but because they play a central role in the current reform debate (*see* Figure 17.1).

Firstly, we examine the trade-off between financial sustainability and equity – a dilemma rooted in growing healthcare expenditures which challenge governments to question their ability to maintain adequate levels of funding to sustain their health systems. The central question addressed here is whether, in order to ensure financial sustainability, population coverage and benefits from public or statutory sources must be reduced, thus undermining the principle of equity. Secondly, the responsiveness of the health system to citizen expectations (an objective increasingly important in many reforms) is set against financial sustainability. Some strategies aimed at increasing responsiveness may be inefficient and

so may undermine the financial sustainability of the system. Thirdly, we explore the trade-off between responsiveness and equity, acknowledging that many strategies aimed at responsiveness do not apply equally to different population groups, and that it is often the younger and the better educated who benefit most from these strategies.

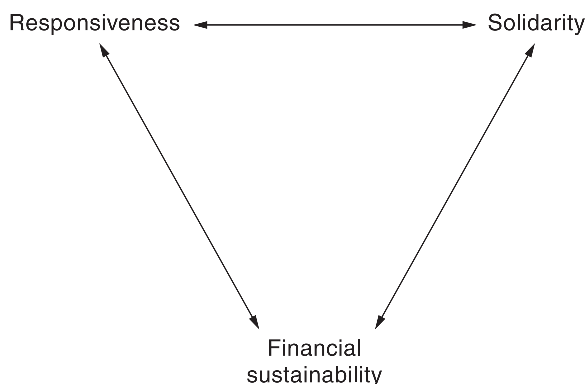

Figure 17.1 Balancing health system objectives.

1 Financial sustainability versus equity

The trade-off between financial sustainability and equity is one of the most central in many health system reforms. We focus first on the trend to increasing healthcare expenditure. Then we review strategies aimed at public sector sustainability by shifting healthcare costs to patients, strategies that often have a negative impact on equity. Finally, we question whether the only way to achieve sustainability is to undermine equity.

Health expenditure trends

Much has been written about the pressures on healthcare expenditure. Typically this is ascribed to three factors: the increasing use of more sophisticated and expensive technology, the ageing of the population, and citizens' increased expectations. Figure 17.2 presents the increase in total health expenditure as a percentage of GDP for a selected group of western European countries between 1990 and 2003. In many countries health expenditures have increased at a faster rate than overall economic growth. In 2003, countries of the European Union 15 devoted 8.8% of their GDP to health spending, an increase from 7.1% in 1990. This percentage varies between countries, and in 2003 ranged from 7.4% in Finland to 11.1% in Germany and 11.5% in Switzerland. In most countries the relative ranking as a percentage of GDP was similar to their rankings on a per capita basis. Health expenditures as a share of GDP increased in every EU country except Finland, where health expenditure growth was positive but lagged behind GDP growth.

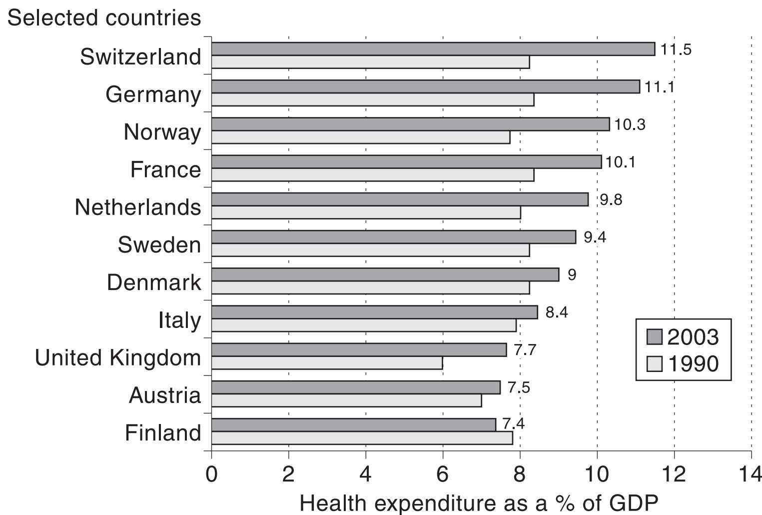

Figure 17.2 Total health expenditures as a percentage of GDP (1990–2003).

Shifting costs to individuals

Cost containment in order to ensure financial sustainability has been a major trigger for many reform initiatives, and a central goal of policy. Reforms have focused on a wide range of supply and demand strategies. Supply strategies have aimed at enhancing provider efficiency. They include the introduction of strategic purchasing,[4] market competition between public and private providers, contracting mechanisms, evidence based medicine, performance-based payments systems, putting primary care in the driving seat, and decentralising provider management. These have had varying degrees of impact but on the whole they have resulted in substantial efficiency improvements.

On the demand side, policy makers have been looking at ways to shift costs to the consumers. Initiatives include reliance on out-of-pocket payment by patients, restriction of statutory packages of benefit, increasing cost sharing, and favouring the introduction of voluntary private insurance, which effectively increases the share of private funding in the health system.

We turn now to a more detailed discussion of these strategies. Among Western European countries, health systems rely on a mix of public and private funding. Despite recent increases in the share of private sources, most funding comes from taxation and social health insurance. The main sources of private funding are private (or voluntary) health insurance, and out-of-pocket payments – direct payments, formal cost sharing, and informal payments. In Western Europe, only Austria, Greece, Netherlands and Portugal draw 30% or more of total health expenditure from private sources (*see* Figure 17.3). Apart from France and the Netherlands, out-of-pocket payments form a larger proportion of private health expenditure than private (or voluntary) health insurance.[5]

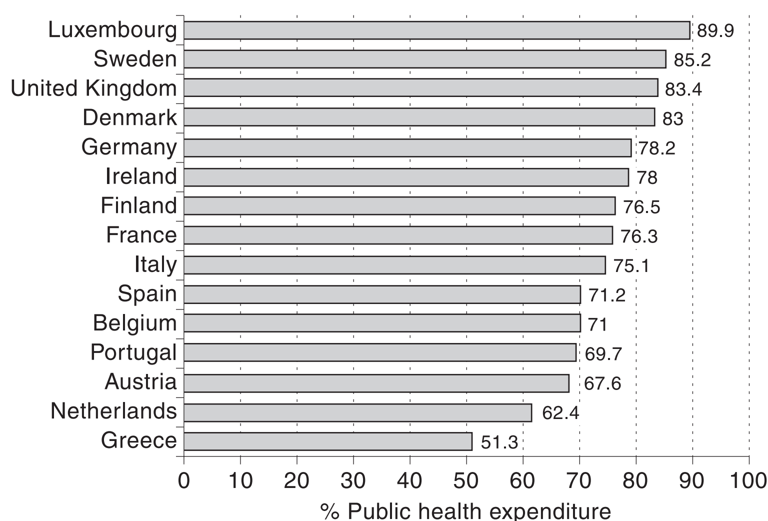

Figure 17.3 Public health expenditure as a % of total in 2003, selected Western European countries.

Political and economic difficulties in increasing tax and social insurance payments have contributed to the appeal of cost sharing as a means of raising much needed revenue for the health sector. Data on private sources of financing such as out-of-pocket expenditures (OOP) and private health insurance (PHI) for selected countries are presented in Table 17.1. The numbers are ranked according to OOP and indicate that both sources of expenditure vary considerably between Western European countries. Evidence suggests that cost sharing is a weak instrument for improving efficiency and containing healthcare costs. Providers heavily determine the demand for health services; service intensity, which is provider-driven, has a key impact on healthcare costs. Cost sharing can only reduce consumer-initiated utilisation and is not therefore the most effective tool for cost-containment. Without compensatory administrative procedures, and exemptions, cost sharing undermines equity with respect to financing and access. In spite of these objections, policy makers continue to use cost sharing widely and consider increasing its role in health funding – in part for political and ideological reasons.

Another strategy for shifting costs to consumers is to increase the role of voluntary private insurance. This can substitute for public coverage (substitutive insurance), or supplement current services (supplementary insurance), or cover for benefits not included in the basic package (complementary insurance).

Overall, private health insurance represents less than 6% of total health expenditure for the countries presented in the table. However, there are exceptions. For example, in Germany and the Netherlands private health insurance provides primary coverage for selected groups in the population, and thus is a more important source of financing. While the uptake is still relatively low, there are many voices in the policy arena calling for an increased role of private insurance. However, because insurers engage in a range of strategies to

Table 17.1 Private sources of financing as a share of total health expenditure, 2003.

	Out-of-pocket payment	*Private health insurance*	*Total private*
Greece	47	2	49
Switzerland	32	9	42
Spain	24	4	29
Italy	21	1	25
Austria	19	8	32
Finland	19	2	24
Denmark	16	1	17
Norway	16	0	16
Ireland	13	6	22
France	10	13	24
Germany	10	9	22
Netherlands	8	17	38
Luxembourg	7	1	10
Belgium			26
Portugal			30
Sweden			15
UK			17

Source: OECD Health Data 2005.
Note: Sum of private and OOP may not equal total private due to other private funds.
Note: No breakdown available for Belgium, Portugal, Sweden and UK.
Germany (2000) data; Spain (1991) data.

rate or select on the basis of risk, voluntary insurance undermines equity. This is unequivocally demonstrated by experience in the European Region.[6]

Risk rating is used to varying degrees and for different types of voluntary health insurance. Voluntary health insurance premiums are rarely income-related and are usually based on individual health risk, or on an estimate of risk at a community or group level. The methods used to set premiums, and the variables used, may have important implications for cost and access.[7]

Insurers that use health status as a variable for risk rating require applicants to complete a medical questionnaire about their health history. Swedish insurers refrain from obtaining information about family history of disease, whereas this is required in Greece, Luxembourg, Portugal and the UK.[8] As a consequence of such information demanded by insurers, applicants may find their coverage reduced or denied. For instance, most insurers set a maximum age limit, and some cancel contracts when people reach retiring age. Moreover, most voluntary health insurance policies are subject to exclusions. For instance, pre-existing conditions are commonly excluded, although some may be covered for an increased premium.

In sum, in spite of wide European diversity, equity is still at the very core of both taxation and social health insurance systems in the region. While there are concerns with the current levels of equity and equity of access,[9] particularly for minority populations,[10] on the whole European systems exhibit high levels of equity. They have all achieved universal coverage with comprehensive packages of benefit largely maintained. In most countries the role of cost sharing, while increasing, is still limited, with important exemptions on equity grounds. Simi-

larly private voluntary insurance still plays only a minor role in the overall funding of healthcare.

Re-examining sustainability

Many advocate a reduction in the publicly or statutorily provided package of benefits, and an increase in out-of-pocket payments or voluntary insurance, as the only ways to deal with the crisis in health sector financing. Hence the question faced by many health sector policy makers today, and the central trade-off explored here, is whether financial sustainability can be achieved only at the expense of equity. This argument is embedded in a broader political one that advocates limiting the welfare state, and asking citizens to take increased personal financial responsibility. This is advanced both on the ground of economic sustainability and also on ideological grounds. Regardless of the key role played by the societal and political contexts, there is a need for a clearer understanding of the parameters of this trade-off between sustainability and equity. There are four important issues that need further examination.

Firstly, if the notion of financial sustainability is reformulated as 'willingness to pay', new options become available to the policy makers. Equity is a central value in European societies, and evidence indicates that populations are willing to pay more, through statutory sources, for increased services and whole population coverage. There seems here to be a gap between the views of the population and the decisions of political elites.

Secondly, the often cited assumption that increasing public expenditure undermines the economy needs to be carefully revisited. While it is true that increasing taxation, or direct levies on labour by augmenting social health insurance contributions, may have a negative impact on market competitiveness, increases in health expenditure relative to GDP growth, provided there is overall economic growth, are less important than is often assumed. The problem for health funding, particularly in Western Europe, is much more one of sluggish, low-growth economies, than of increasing health expenditures at the macro-economic level.

There is also scope for diversifying funding sources in order to minimise the impact of health spending on unit labour costs. Policy makers can increase sustainability and reduce the pressures on equity by exploring other sources of taxation (for example, from selected use of VAT, so-called 'sin taxes' on alcohol, tobacco, and so on). At the very least they can rebuff the argument that increases in cost sharing and voluntary insurance have no negative impact on the economy. Experience in the United States proves this point.[11] Unregulated increases in private insurance undermine employment markets, increase labour costs and reduce workforce mobility due to risk-related premiums for pre-existing conditions.

Thirdly, policy makers need to differentiate between financial and social sustainability, and consider the implications of the latter, including the implications for economic viability. For example, in terms of social stability, the benefits of covering 'marginal' populations are considerable. There is ample evidence from across Europe of the corrosive effect of excluding minority groups from social provision.[12]

Health coverage contributes to social cohesion. It is an enabling factor which

ultimately fuels increases in economic productivity, and links with the next consideration.

Fourthly, in assessing trade-offs between sustainability and equity, the hidden costs of failing to maintain full and equitable coverage must be factored into decision making. There has long been a recognised link between health status and economic productivity in developing countries.[13] It is now increasingly clear that this link applies also in developed countries.[14] To concentrate on mechanisms for increasing financial sustainability that reduce coverage for the poor may therefore prove to be economically short-sighted.

In the light of all these considerations, the trade-off between sustainability and equity may not be as problematic, nor pose as serious a threat, as policy makers envision. They need to factor in the consequences of failing to invest socially and as well as economically.

2 Social responsiveness versus financial sustainability

Responsiveness has become an increasingly important objective in many health systems since the early 1990s. In many countries in the Region there is a noticeable trend towards increasing social responsiveness, part of a broader reform movement concerned with citizen empowerment. However, social responsiveness can be seen to present challenges to financial sustainability because in some instances giving greater weight to patient preferences, whether through improving the physical environment of health service provisions, or by increasing provider choice, may result in higher health service costs. This section reviews the evidence for an unavoidable trade-off between financial sustainability and social responsiveness.

Firstly, we need to re-emphasise that the intentions of responsiveness go beyond those of health gain or efficiency. For instance, there are many interventions not deemed to be effective with respect to health gain, or efficient with respect to value for money, that nonetheless respond to citizens' expectations. Prioritising responsiveness sometimes means opening the door to such interventions. The choice becomes more critical when their cost, unsupported by scientific evidence, begins to threaten the financial sustainability of the system itself. Increased pressure on resources associated with increased responsiveness may also put the spotlight on interventions whose appropriateness previously went largely unquestioned. This raises the spectre of increased cost and diminished financial sustainability, positing a direct trade-off between responsiveness and sustainability.

Clearly how the trade-off is resolved depends on the extent to which different societies and policy makers are willing to allocate limited resources to interventions that respond to the wishes of citizens, but that cannot be shown to impact on either health or cost-effectiveness. On the whole, there is evidence that policy makers are prepared to invest in these areas. In a recent comparison between social health insurance (SHI) and National Health Service (NHS) systems, Figueras *et al*. illustrate this, showing what seems to be higher satisfaction/responsiveness in SHI countries. The central question for policy makers is this: 'Is greater social responsiveness worth the additional costs?' The study concludes that 'this requires a societal rather than a technical judgment', noting that 'SHI

systems respond to a way of understanding the world' and calls for 'a framework for making policy based on that societal perspective'.[15]

One should be cautious about oversimplifying the decisions policy makers face in these circumstances. There is a wide and diverse range of strategies available, and scope for improving responsiveness for little or no additional expenditure – for example, by ensuring that cost-effective interventions are delivered in a way that responds to users' expectations. Responsiveness can be enhanced by better staff training, by improving amenities, increasing choice, or reducing waiting lists.

The challenge for policy makers is to disentangle the various elements as they interact in particular contextual circumstances, and as they relate to the values of a given society. Policy makers may struggle to decide between the marginal cost benefit of investing in better hospital rooms, or user-friendly information systems, and that from putting the same resources into proven clinical interventions. To explore some of these tensions we now focus briefly on one particular strategy which has been central to enhancing responsiveness in recent years – increasing the choice of insurer and provider.

Increasing choice

The right to exercise a degree of choice when accessing healthcare is often seen to play an instrumental role in increasing responsiveness. In practice, however, the implementation of choice strategies is rather complex and has often resulted in unintended consequences. In some cases the two objectives of social responsiveness and efficiency are at odds with one another, and trade-offs are required.

During the 1990s a relatively new dimension of choice emerged in a number of SHI countries such as Germany and the Netherlands, where citizens were given the right to choose between competing insurers or sickness funds. Admittedly, the focus of this reform was not only to increase responsiveness but also to unleash the perceived benefits of market forces. The degree to which consumers now change their insurance funds, the impact of these changes on economic efficiency in the overall system, and the impact on equity (which we address in the section below) remains a contentious political issue.

There is clear evidence that countries with a multiplicity of sickness funds have higher administrative costs, and that these increase significantly with the introduction of choice and competition between sickness funds.[16] This appears to be linked to the costs of marketing and advertising, to risk selection and to management costs. With respect to the impact on economic efficiency (and so on the sustainability side of this trade-off), the question of whether the increased costs resulting from competition between insurers will be offset by the hoped for (but not yet proven) efficiency savings from market competition remains unanswered.

Consumers in most Western European countries have the right to choose primary care providers. In SHI systems, consumers can also choose ambulatory specialists and hospitals, albeit in some cases through a gatekeeper system (e.g. the Netherlands). In NHS countries, the choice of hospital provider has traditionally been relatively restricted, although this has changed recently in many countries. Norwegian, Danish and Swedish patients, for example, are now allowed to choose any hospital outside their county of residence. Similarly in other NHS type systems such as the UK and Spain, patients have seen their choice

of hospital greatly increased. The introduction of choice in these countries was aimed at increasing competition among providers, encouraging them to operate more efficiently, and also to be more responsive to patients.

Evidence on the impact of these various strategies to increase choice is still incomplete. While there has been an increase in provider responsiveness, the extent to which this has been accompanied by efficiency is unclear. For instance, there are concerns about the degree to which information given to consumers can sometimes lead to provider capture. The evidence is clearer when looking at choice of primary and ambulatory doctors in countries without a primary care gatekeeper function. In countries such as France and Germany, the absence of a gatekeeping mechanism often results in high levels of unnecessary service use. This is even worse when free choice of ambulatory provider is combined with fee for service schemes: this creates perverse incentives and encourages provider-induced demand. Consequently many of these countries have been trying to bolster sustainability by putting in place systems aimed at curtailing choice and reducing moral hazard.

In Germany, while most citizens are said to have a family physician, they frequently choose directly to consult office-based specialists. With the implementation of user charges for physician and dentist visits in 2004, the number of physician visits decreased by 10% and the rate of direct consultations with specialist fell by 7% (60 to 53%). In contrast, the rate of referred consultations (from family physician to specialist) increased from 40% to 47%.[17]

Similarly, in France, recent reforms are aimed at increasing cost-effective choices of treatment, and seek to control costs by reducing patient choice of specialists by the introduction of a gatekeeping function.[18] Incentives are provided to GPs (annual payment for each patient registered) and patients are exempted from any co-payment for a doctor visit. By contrast, patients receive a lower reimbursement if they visit a specialist without a referral, and specialists can charge higher fees for such direct consultations. So far, in 2004 only 1.8% of patients have consulted via a referring physician, and only 10% of GPs have joined the scheme.[19] The extent to which this approach will have a significant effect in curtailing inefficient utilisation, once the programme goes into full force in 2006, is unclear.

In Denmark, disincentives are introduced to reduce choice. Residents can choose to belong to one of two groups. In the first group residents are registered with a GP in their geographical area, have free access to both GPs and specialists, but are required to have a referral from their GP to see a specialist.[20] If they visit a specialist directly they are liable to pay the full fee. Changing to another GP is allowed every six months, but in some counties a small fee for this is required. Official figures are unavailable but switching between doctors is considered to occur infrequently. In the second group residents have a free choice of GP and specialist, but are subject to a co-payment. Less than 2% of the population has opted to be in this group.[21]

Many countries in the Region have also introduced strategic purchasing reforms, with the aim of increasing provider efficiency. In these schemes purchasers, such as insurance funds or regions, may contract with providers selectively in the light of cost-effectiveness and quality criteria. Although, as noted above, many countries also encourage consumer choice of provider, in practice choice available to the consumer and the purchaser cannot be equally

met. Strategic purchasing shifts the balance of power to the purchaser agent, thereby reducing or even removing the choice available to the consumer.

Evidence suggests that in all these reforms the trade-off is resolved in favour of financial sustainability. The choice of provider is curtailed by purchasers, or linked to some financial disincentives, with social responsiveness taking a back seat. In many instances, the consumer has to set the utility derived from choosing her or his provider, against the out-of-pocket costs incurred. There is, then, a money barrier to the exercise of choice that will clearly affect the poorest service users. This raises fundamental equity issues, and leads us to the third trade-off we consider in this chapter.

Responsiveness versus equity

The third set of trade-offs closes our conceptual triangle (*see* Figure 17.3 above) – it counterpoises responsiveness and equity and argues that strategies to increase social responsiveness, now at the centre of so many reforms, will have a negative impact on equity. In no small part this is because of the inequitable way health systems respond to users' expectations. We now discuss whether strategies to improve responsiveness benefit all population groups equally, or some more than others.

Studies of healthcare utilisation reveal that higher-income groups utilise services more often than low-income groups, although the latter have greater health needs.[22] There may be several reasons for this. For instance, access to services may be relatively more costly both in time, and in earnings forgone, for those in lower income groups, who are therefore less able to obtain good services.[23] In Sweden, those who financially assessed their situation as being poor were ten times more likely to forgo care as those who assessed their financial situation as being good.[24] In Denmark, the probability of obtaining dental care is positively related to household income.[25]

Evidence also shows that those more active in exercising choice are usually younger, healthier, more affluent and better educated.[26] This is demonstrated by the introduction of choice of insurers in Germany and the Netherlands.[27] The evidence shows that healthier, younger and higher-earning individuals not only shift funds more often, but also into funds that are cheaper or offer better benefit packages.[28,29] This is further illustrated in a recent report in the UK which argues that current measures to increase patients' choice favour 'the healthy, wealthy and demanding' and those who have access to information and transport.[30] The report notes that people from lower socioeconomic groups had 20% fewer hip replacements than people from other groups, despite an estimated 30% higher need. Also people from social classes IV and V had 10% fewer consultations about preventive care than those from social classes I and II.

It is not only that those from lower socioeconomic groups experience less social responsiveness than those from higher status groups (who have higher expectations and the confidence and negotiation skills to pursue their entitlements). The poor also have access to fewer services, which tend to be of poorer quality and seem to result in relatively poor health outcomes. The suggestion is that, given the scarcity of resources, system changes aimed at increasing social responsiveness, and particularly choice, may result in better and more expensive amenities for some, while reducing the level of essential clinical services available to others.

On one hand, the principle of equity is at the core of the European social model. On the other, choice is enshrined in the European internal market and the freedom of movement of people, services and goods. This dilemma is well illustrated by the current debate about patient cross-border mobility between EU countries.[31] While the number of patients crossing borders is still relatively small, there is a trend towards progressively greater mobility with respect to both the volume and the range of services involved. This recent trend has been underscored by the rulings of the European Court of Justice to protect freedom of movement, and the discussions around the formulation of the new services directive. Although health services fall under the principle of subsidiarity, increasing cross-border entitlement is seen by many national governments as jeopardising the sustainability of their own health systems. They fear that the costs of treating their more mobile citizens in other European countries will undermine cost control, because reimbursing patients treated abroad will use up a large part of their budget. Permitting cross-border entitlement could result in limiting services available for those unlikely to seek care in this way – usually the older, poorer and sicker citizens. This threatens both financial sustainability and equity.

One policy response to this trade-off is to reduce responsiveness to the population's lowest common denominator in line with 'the equity in poverty' argument, i.e. offering equally unresponsive services to everyone. Arguably this would meet the equity principle, but it would surely encounter resistance in most of our societies, particularly given the strategies in place to empower citizens. Also, as noted by den Exter in a recent analysis of patient empowerment in Europe, '. . . these developments may incur increased costs, threatening social equity and financial stability, but they are a consequence of a democratic evolutionary process in many health systems and cannot be ignored.'[32]

Perhaps a more acceptable response to this trade-off is to focus efforts on achieving wider access to information about services, and on tailoring support through positive discrimination strategies that increase access and choice for the underprivileged. There is a wide range of measures to make healthcare choices more effective for the poorest. These aim to overcome those barriers that prevent people exercising full choices, including lack of information and knowledge, language problems, inadequate transport and information technology, and disability. There are also many examples of strategies to prevent discriminatory practices. For instance, some countries with free choice of insurer, such as Germany and the Netherlands, use active regulation to prevent risk selection, including open enrolment and financial redistribution formulae between insurers.

In all these cases addressing this trade-off involves investing substantial additional financial resources. It begs the question: 'Are societies prepared to pay for equity in responsiveness?' Interestingly this brings us back to the first set of trade-offs discussed here – that between sustainability and equity.

Can we have it all? Managing the paradox

This essay has selected and explored three of the many sets of trade-offs that policy makers have to face. They have been chosen because of their key role in the healthcare reform debate and because they illustrate the complexities and difficulties of managing paradox.

Trade-offs take place all the time and on a range of levels. Sometimes they are implicit, sometimes explicit, but ultimately at least some of them are necessary. It is scarcely surprising that we have failed to identify any magic recipe that will manage all the paradoxes or deliver all our competing demands for fair, responsive and affordable health systems. Rather we have attempted to offer some insights into their nature, and the nature of the task of balancing competing demands.

Our most compelling conclusion is that this is fundamentally a debate based on values which will vary between different populations. If that debate is to be inclusive and effective, policy makers should avoid confusion between the choices that are value laden, and the choices that hinge on technical debate. There is a need, therefore, for an explicit framework that sets out the evidence and the options, that facilitates an open debate about the true nature of the trade-offs to be made. This will allow public participation in decision making and public ownership of the preferences expressed.

Our close look at the three trade-offs dealt with here has revealed interesting, and perhaps some unexpected, dimensions of choice for policy makers, and something about the true nature of choosing between health policies. In many instances specific trade-offs are poorly understood and overly politicised. This exposes policy makers to unnecessary pressures. The degree to which policy makers really have to exercise absolute choice, or the extent to which trade-offs are entirely necessary, may be much smaller than we thought.

The first trade-off that we considered demonstrates this clearly. Improvements in the efficiency of service delivery may not be sufficient to address cost pressures and secure financial sustainability. It is hard to contest that equity is likely to suffer if measures to control demand and achieve substantial savings are introduced as the core response to cost pressures, when these depend heavily on shifting costs to patients. This suggests the need for trade-off between sustainability and equity, one which is central to the political debate in most reforms. However, the premise that the only way to address financial sustainability is to reduce levels of equity is a false one which requires some fundamental qualifications.

Financial sustainability is not about absolutes. It reflects a population's 'willingness to pay' – in this case for equity. This perception allows for more flexibility than is sometimes thought. Some societies may be willing to devote increased resources to healthcare in order to pay for equity, either by shifting funds from other areas of public expenditure (such as defence) or by increasing contributions. These strategies need not threaten a society's broader economic viability. Further, the imperative of financial sustainability should be set against that of social sustainability and the wider societal implications of excluding poorer populations. Finally, the benefits of equity with respect to economic productivity may ultimately offset the costs of universal population coverage. We suggest that policy makers need always to question the absolute of any trade-off, to look for the relative, and to take into account the wider societal context in which they make choices.

The requirement for the second trade-off is based on the argument that measures aimed at increasing responsiveness, so central to many reforms, decrease efficiency, and will therefore undermine financial sustainability. Again, however, there are a number of important qualifications to be considered.

Sustainability is in many respects about willingness to pay rather than about given financial limits. Arguably, if citizens are willing to pay collectively for social responsiveness, responsiveness ceases to threaten sustainability. The use of resources for responsiveness ceases to be seen as 'inefficient' if, in addition to improved health status, it is fully valued for itself, and recognised as a core health system goal. What is more, responsiveness includes a wide range of measures many of which may require relatively few additional resources in order to have a potentially significant impact. Ensuring dignity, confidentiality and effective communication can in part be addressed by reforming medical curricula and training. We argue that there is much scope for improving responsiveness without jeopardising sustainability.

However some elements of responsiveness must entail some cost. In particular the dimension of choice of provider and insurer poses very clear trade-offs with financial sustainability. Here, again, policy makers can benefit from a detailed examination of the trade-off. The core issue is not simply the right to choose, but how appropriately that choice is exercised. It is hard to defend an arrangement that demonstrably gives rise to inappropriate, unnecessary and therefore inefficient utilisation of services. Better education, more outreach to, and dialogue with, the public, and more explicit statement of benefits, can all help tackle inappropriate demand. Such efforts may be more effective, and more equitable, than measures to introduce disincentives through cost sharing, since these inevitably hurt the poor and threaten equity. Similarly, focusing on ways of ensuring appropriate levels of access to good quality general practitioners as gatekeepers may be enough to satisfy the demand for choice in many societies. These efforts may prove just as acceptable as, and more efficient than, offering choice of specialists for each episode of care. Policy makers are already aware that there are different perceptions of choice and different importance ascribed to it in different countries, contexts and cultures.

Consideration of the third trade-off leads to similar conclusions about the danger of considering trade-off in absolute terms. While there are legitimate concerns that increases in health system responsiveness, particularly the ability to choose, can sometimes have a negative impact on equity, the link is not an inevitable one. Given that limiting social responsiveness for all in order to achieve greater equity would not be acceptable in most of our societies, the policy maker must look to invest and target resources at the less privileged, so as to ensure 'equal responsiveness for equal need'. This does however, brings us back to the first trade-off, and to ask whether society is willing to pay for equal responsiveness across all social groups. This trade-off is a function of society's willingness to pay for equity. As with the other examples addressed here, there are no simple answers. However, it is clear that an explicit discussion of the options, the values and implications of any given trade-off, can reduce the complexity of any decision, remove some of the artificial barriers to managing the paradoxes, and pave the way for solutions that can be owned by the whole of society.

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