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Health System Related Trade-offs

Survey Results Using the Conflict Scale

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ABSTRACT

Economic theory recognises the existence of trade-offs between objectives. In the health economics literature this has resulted in the analysis of a number of questions, most notably the trade-off between the quantity and quality of health. Other trade-offs which have been analysed and quantified include health improvement versus the initial severity of a patient's health and equal life expectancy versus maximum aggregate life years.

The Conflict Scale is an instrument which forces survey respondents to make choices which might be avoided by other forms of questionnaire. It was developed to allow the pairwise comparison of values which are likely to clash.

This paper reports results from the use of the instrument with a representative sample of 466 Australians. The values included in the survey related to different health outcomes, patient choice, patient versus doctor decision making and responsibility for the payment of medical expenses.

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1 Introduction

Economic theory recognises the existence of trade-offs between objectives. In the health economics literature this has resulted in the analysis of a number of questions, most notably the trade-off between the quantity and quality of health. Other trade-offs which have been analysed and quantified include health improvement versus the initial severity of a patient's health and the equalisation of health between people versus the maximisation of health (measured, for example by total life years or QALYs) irrespective of its distribution. .

Other trade-offs have been recognised but have received little empirical attention. These include equal access to services versus the length of life, equal access versus the right to priority, faster treatment; equal access to treatment versus the right (through private health insurance) to better health care. In the once vigorous debate over supplier induced demand, it was commonly asserted (by proponents) that patients will (and presumably wish to) allow doctors to make decisions for them. Opponents disagreed, asserting that patients make (and presumably want to make) final decisions. Remarkably, the pivotal question has not been empirically tested.

A third set of trade-offs relate to procedural issues and, in particular, whether or not individuals would be prepared to reduce choice over a range of decisions and outcomes to reduce the anxiety associated with decision making.

The present paper is a summary of the results of a representative population survey of 466 Australians which sought quantitative answers to these questions. The issues included in the survey are summarised in Box 1. The survey employed the 'Conflict Scale'. As explained in Section 2 below, this was designed to make pairwise comparisons between the importance of difficult issues or goals. The opportunity cost of high priority for one goal is a necessary reduction in the priority given to another. This overcomes the problem of prioritising every desirable attribute at the top of the scale and encourages a deeper consideration of the questions (and the underlying values) as the benefit of a high priority for one issue must be weighed against the cost of lower priority for the paired issue.

The section below summarises the methods used in the survey. Section 3 presents the question asked and survey results. In this paper only descriptive results are presented. The full questionnaire is reproduced in Appendix 1. It includes additional questions concerning personal and social goals. Results are presented in Richardson et al. (2012).

Box 1 Survey subject matter

1 Health sector objectives

Life expectancy	Equality
Qualify of Life	Sharing
Access	Choice

2 Personal choice

Anxiety	Drugs
Cost	Doctor
Medical care	Hospital

3 Decision maker

Doctor, patient

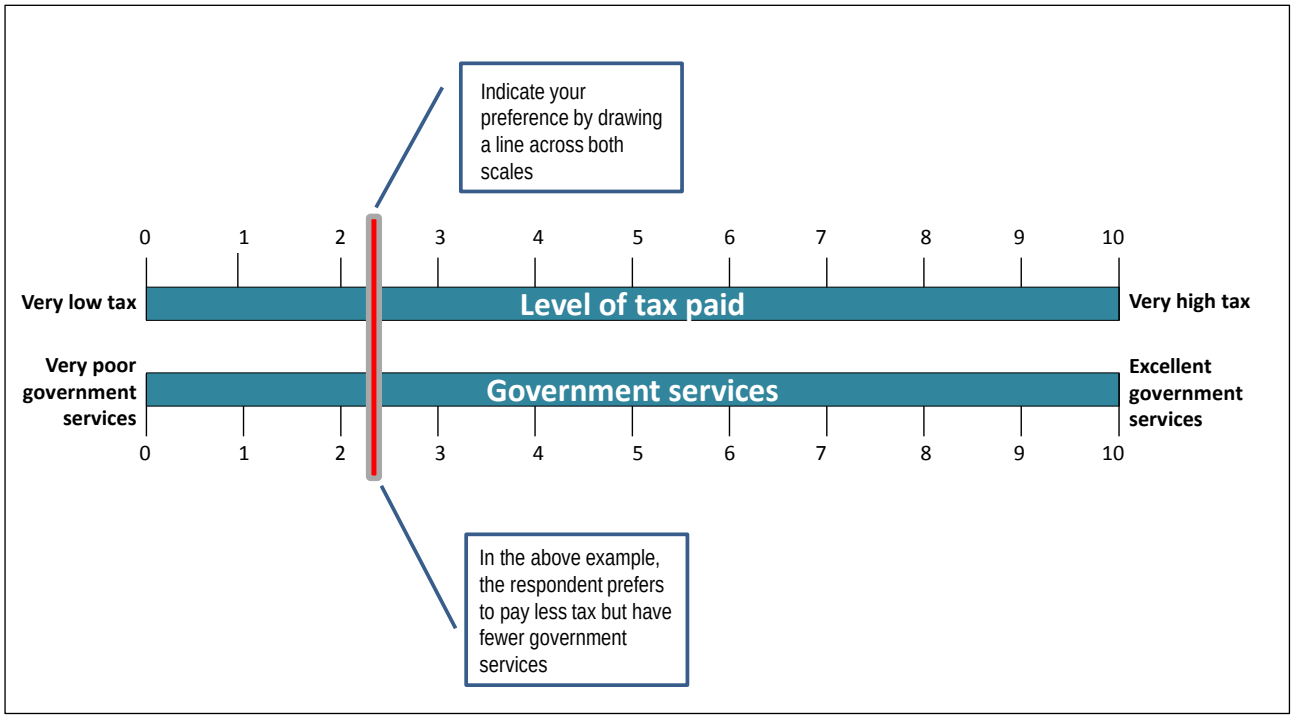
4 Who pays

Patient
Private Health Insurance
Medicare

2 Methods and data

The Conflict Scale is illustrated in Box 2. The two possibly conflicting values in the illustration are 'the desire to minimise the personal contribution to taxation' and 'the wish to have excellent public services.'. Respondents can indicate their relative importance by trading them as if they conflicted as shown on the scale. The software employed allows individuals to move a slide right or left to indicate their preferred trade-off between the two goals.

Box 2 The Conflict Scale



Data

The survey was administered by an online survey company, CINT, to its enrolled panellists who were selected to be representative of the age-gender-education profile in Australia. The full questionnaire is reproduced in Appendix 1. In addition to these questions respondents were asked to complete the AQoL-8D and PWI quality of life instruments.

Data were edited using multiple criteria. From experience some panellists complete questionnaires rapidly and randomly to attack the small payment offered by the panel companies. Where this had obviously occurred (for example the same response was given for every question) CINT replaced the respondent. In addition, however, a more rigorous edit procedure was used to eliminate unreliable results. An individual's responses were edited out of the survey when they met any of the following criteria:

1. Time spent answering questions was implausibly low
2. Long sequences of questions were given identical answers
3. Answers to two duplicated questions relating to hearing and vision varied by more than one response category
4. A flat profile existed for the Personal Wellbeing Index (the same response category – from the 11 available – was ticked for all 8 questions)
5. Inconsistent answers were given for the two Medicare payment questions (eg as illnesses became worse Medicare, then the individual then Medicare should pay most)

Table 1 classifies the respondents according to age, gender and education. After editing, 466 respondents were retained. Reflecting the use of quotas there were approximately equal numbers of males and females and the age distribution reflected the Australian demographic structure. There were approximately equal numbers of respondents in the three education categories which were those whose highest level of education was high school, a diploma or university degree.

From Table 2, 6.4 percent were unemployed and seeking work. This represented 11.4 percent of those in work or seeking work which is somewhat higher than the Australian norm. Table 3 reveals a uniform distribution of respondents across the income spectrum, although these data are notoriously unreliable. From Tables 4 and 5 there was a wide spread in the importance of religion in a person's life and the political leaning of respondents was similar to the overall Australian population. The ethnic composition of the sample was largely European (30.2 percent) or Anglo Saxon (53.5 percent) with Asian the only significant sub-group (7.6 percent). 62.4 percent were married or lived with a partner and 20.4 percent were single or never married. 62.9 percent had children.

Table 1 Sample characteristics: age, gender and education

Gender	Age	Highest level of education attempted			Total
		High school	Diploma or certificate or trade or TAFE	University	
Male	18-24	6	5	9	20
	25-34	8	10	14	32
	35-44	12	15	11	38
	45-54	13	13	12	38
	55-64	58	10	8	76
	65+	12	14	13	39
	Total	109	67	67	243
Female	18-24	8	8	10	26
	25-34	13	14	17	44
	35-44	14	14	15	43
	45-54	12	13	12	37
	55-64	12	11	11	34
	65+	13	13	13	39
	Total	72	73	78	223
Total	18-24	14	13	19	46
	25-34	21	24	31	76
	35-44	26	29	26	81
	45-54	25	26	24	75
	55-64	70	21	19	110
	65+	25	27	26	78
	Total	181	140	145	466

Table 2 Sample characteristics: employment

	Frequency	Percent
Full-time	143	30.7
Part-time	87	18.7
Unemployed, seeking work	30	6.4
Pensioner, retired, not seeking work	131	28.1
Student	24	5.2
Homemaker	51	10.9
Total	466	100.0

Table 3 Sample characteristics: pre-tax gross household income (all sources)

	Frequency	Percent
Prefer not to say	64	13.7
Below $350pw (less than $18,200pa)	39	8.4
$350-649pw ($18,200-33,748pa)	79	17.0
$650-999pw ($33,800-51,948pa)	78	16.7
$1000-1399pw ($52,000-72,748pa)	88	18.9
$1400-1999pw ($72,800-103,948pa)	56	12.0
$2000-2999pw (104,000-155,948pa)	40	8.6
Above $3000pw (above $156,000pa)	22	4.7
Total	466	100.0

Table 4 Sample characteristics: religious following

	Frequency	Percent
It plays a major role in my life	56	19.65
It plays a somewhat major role in my life	55	19.30
It plays a somewhat minor role in my life	57	20.00
It plays a minor role in my life	56	19.65
It plays an insignificant role in my life	61	21.40
Total	285	100.0
Not applicable	181	
Total sample size	466	

Table 5 Sample characteristics: political preference

	Frequency	Percent
Labor	171	36.7
Liberal	209	44.8
Greens	86	18.5
Total	466	100.0

3 Questions and results

3.1 Health sector objectives

All health systems aspire to equity and efficiency. However there are multiple dimensions to these broad objectives and questions in this section sought to assess their relative importance.

The preface to the questions read as follows:

The health system has many possible goals:

- *Maximising health (e.g., total years lived, no matter who gets them)*
- *Providing equal access to health care (e.g., the same queuing for services and travel time)*

- *Minimising suffering (improving quality of life for the very worst off)*
- *Reducing inequities of health between groups of people (rich/poor/aboriginals/city/rural*

Individual questions were:

1.1 Which is more important: Quality of life or length of life?
Comment: *Would you prefer that everyone lived in perfect health but for not as long, or that everyone lived longer but spent their final years in constant pain and psychological distress?*

1.2 What should Medicare policy be: Equal life expectancy or high average length of life
Comment: *High average length of life means some live very long but others die when they are young.*

1.3 Which is more important: equal (fair) access to health (waiting time) or length of life
Comment: *Providing identical access to health services may stretch resources so far that the quality of services falls and life expectancy falls.*

1.4 Which is more important: Severity or improvement?
Comment: *Helping those who are suffering the most even if their health cannot be improved very much or helping those whose health can be improved the most even if they are not suffering very much.*

1.5 Which is more important: Sharing resources versus maximising global health?
Comment: *Some illnesses are expensive to treat. Money would buy more health if it was all spent on a smaller number of people who were not expensive to treat.*
Extreme 1*: We should share resources equally even when illness is expensive to treat and the budget will run out, no matter what the treatment cost.*
Extreme 2*: We should only spend money on patients who would gain the most even though others would miss out.*

1.6 Which is more important: equal access or the right to pay for faster services?
Comment: *Some people argue that everyone should have equal access to health care and individuals should not be allowed to pay for faster access to services than others. Others argue that people should have the right to spend their own money to get* ***faster*** *access. In this case, queues would vary according to individual spending. Should people be allowed to pay to reduce their waiting time for health care?*

1.7 Which is more important: equal treatment for all or the right to pay for better health care?
Comment: *Some people argue that everyone should have access to the same quality of care. Individuals should not be allowed to pay for better services than others. Others argue that people should have the right to spend their own money to get better health care. In this case, treatment would vary according to individual spending. Should people be allowed to pay for* ***better*** *health care?*

Results from these questions are given in Table 6a and 6b. When presented with the abstract issues, respondents did not place great emphasis upon maximising the length of life (question 1.1). On the 10 point scale, the average quality of life (QoL) score was 5.16 points above the average score for length of life. Equal access was strongly favoured to length of life (question 1.3) and length of life was given the same average score as equal life expectancy (question 1.2).

Each of the questions reported in Table 6b tested some widely accepted view in health economics. Quality adjusted life year (QALY) maximisation would imply the maximisation of health gain irrespective of suffering per se. Respondents significantly rejected this (question 1.4). Similarly, it implies maximising health, not sharing when this lowers average health. Again respondents disagreed with this (question 1.5). Questions 6 and 7 conflicted the personal right to priority access and better quality care against the social goal of equal treatment. Respondents gave greater weighting to the latter, social goal.

Table 6 Results: maximising life vs QoL and equality*

Question	Scale A*	Mean	Scale B*	Mean	SE	Diff	t**
6a Maximum health							
1.1	Quality of life	7.58	Length of life	2.42	0.101	5.16	0.54
1.2	Equal LE	4.98	Length of life	5.02	0.133	-0.004	0.15
1.3	Access	6.23	Length of life	3.87	0.133	2.46	9.25
6b Fairness, compassion							
1.4	Suffering	5.98	Max health	4.02	0.120	1.96	8.17
1.5	Share	6.74	Max health	3.36	0.122	2.94	14.26
1.6	Equal access	5.89	Pay for priority	4.11	0.150	1.78	5.93
1.7	Equal treatment	5.60	Pay for quality	4.40	0.149	1.20	4.02

Key
* scales were from 0-10
** t = (mean-score -0.5)/se

3.2 Personal choice versus paternalism

Choice: At the personal level there is a demand for choice but choice imposes responsibility and anxiety which may be mitigated or avoided in a paternalistic system.

This set of questions was prefaced by the following comment: *Choice puts you in control of what happens to you. It may result in better outcomes for you. However you may face too many choices which are complex so you make mistakes this may make you anxious about making choices*.

Individual questions were as follows:

1. Financial cost of health care (If Medicare did not exist) which is more important: maximum choice or anxiety over choice (fixed cover, fixed cost)?
   Comment: *multiple schemes with different levels of cover means lower cost insurance (you pay more when sick)*
   or no time or anxiety over choice *(fixed cover, fixed cost).*
2. Choice of drugs: control events or reduce anxiety?
   Comment: *Different drugs have different side effects. Choice may cause anxiety if the choice is difficult and important.*
3. Choice of hospital/doctor: control events or reduce anxiety
   Comment: *Suppose you were allowed to select your own doctor to carry out an operation.*
4. Choice of quality of care: control events or reduce anxiety
   Comment: *Suppose you could buy more or less care or pay a fixed price and let the*

doctor select the type of care you get. Buying care means you can pay less than the fixed price of pay more and possibly get better care.

Results reported in Table 7 indicate a very strong desire for choice and relatively less concern with the anxiety and responsibility that this imposes. This was particularly strong with respect to the choice of an insurance scheme where the mean score was 7.1 (question 2.1). In this case, 33.3 percent of respondents rated choice as 9 or 10 on the scale. Importantly, this question abstracted from Medicare and focused upon the effect of competition upon premium costs. A significant caveat is that some respondents may have been influenced in their answer by the actual Australian system of private health insurance (PHI). Despite this, the preference for choice is also reflected in the questions relating to treatment, drugs, doctors and quality (question 2.3-2.5). However the option of reducing anxiety was of some importance. Except for choice of scheme, its score was above 4.11 in each question and between 7-11 percent of respondents gave the paternalistic option one of the top two scores.

Table 7 Results: choice within the health sector

Question	Scale A*	mean	Scale B*	mean	SE	Diff	t
2.1	Choice of scheme	7.10	No anxiety	2.90	0.111	4.20	18.9
2.2	Choice of treatment	5.77	No anxiety	4.23	0.129	1.54	5.97
2.3	Choice of drugs	5.37	No anxiety	4.63	0.131	0.74	2.82
2.4	Choice of doctor	5.89	No anxiety	4.11	0.130	1.78	6.85
2.5	Choice of quality	5.88	No anxiety	4.12	0.122	1.76	7.21

Key
* scales were from 0-10
** t = (mean-score -0.5)/se

3.3 Decision making by doctor or patient

Who makes decisions: The theory of Supplier Induced Demand implies that doctors are the dominant decision makers in the health sector. The likelihood that this is true increases if people wish doctors to make decisions. However this question has seldom been asked. But the answer is likely to vary with the severity and complexity of the health state.

This question had the preface comment: *Some people argue that doctors have better judgement and, therefore, doctors should make all treatment choices. Others argue that patients should choose and doctors should only advise.* Individual questions were as follows:

1. Who should make treatment decisions about minor illnesses (*eg colds, aches, anxieties)*?
2. Who should make treatment decisions about moderately serious illness (*eg flu, high blood pressure, moderate depression*)?
3. Who should make treatment decisions about serious illnesses? (*eg, heart disease, respiratory disease, COPD, cancer*)?
4. Who should make treatment decisions about chronic ongoing illnesses? (*eg, asthma, diabetes, chronic depression*)?

5. When should decision makers listen to people's opinions – before or after they have an illness?
   Comment: *People may feel fear, dread and anxiety before they have experienced an illness and therefore want comprehensive expensive care. After they have experienced the illness they may find that the fear and dread were not fully justified.*
   The choice: Take account of people's opinions (i) before an illness, allowing for their anxiety and errors; OR (ii) after they have the experience of the illness, and ignore anxiety and fear.

Table 8 indicates the respondents wish to have greater responsibility than the doctor when the illness is described as 'minor'. This changes with the severity of the illness. When this is described as 'serious' the mean response for choice is 2.92 and 42.3 percent of respondents gave a score of 9 or 10 to doctor decision making – indicating the possibility of supplier induced demand.

The final result in Table 8 relates to the issue of decision ('ex ante') versus realised ('expost') utility. Both concepts are used in the literature. Our respondents indicated that both should be taken into account.

Table 8 Results: decision making: patient or doctor

Question	Severity	(a)	Mean	(b)	Mean	SE	Diff	t
3.1	Minor	Patient	5.73	Doctor	4.27	0.137	1.46	5.32
3.2	Moderate	Patient	3.70	Doctor	6.30	0.121	-2.66	10.74
3.3	Serious	Patient	2.92	Doctor	7.08	0.131	-4.16	15.87
3.4	Chronic	Patient	3.25	Doctor	6.75	0.131	-3.50	13.35
3.5	Listen	Before ill	4.94	After ill	5.06	0.108	-0.12	0.56

3.4 Who should pay for medical care

Medical care is primarily financed from one of three sources in Australia: tax funded Medicare, subsidised PHI and personal (patient) out of pocket 'co-payments'. Two sets of conflicts were therefore created: personal cost versus Medicare (ignoring PHI) and PHI versus Medicare (ignoring personal costs).

Personal costs: There has been ongoing dispute concerning the appropriate level of co-payments in the health sector. Little attention has been given to the relationships between these and the severity of the illness. The relevant questions were prefaced with the statement: *Some people argue that people should look after themselves. Others argue that the cost of illness should be shared by everyone through taxation (ie Medicare)*.

1. Who should pay for minor, inexpensive illnesses (*eg, colds, aches, anxieties*) the patient or Medicare?
2. Who should pay for moderately expensive illnesses (*eg, flu, high blood pressure, moderate depression*) the patient or Medicare?
3. Who should pay for serious, expensive illnesses (*eg, heart disease, respiratory disease, COPD, cancer*) the patient or Medicare?

Private Health Insurance (PHI): PHI in Australia provides the vehicle for avoiding egalitarianism. It gives the right to spend private income on better or quicker services. Little research has been carried out to determine whether this balance should vary with the type of service.

Questions in this group were prefaced with the comment*: Some people argue that private health insurance gives greater choice. Others argue that taxation is fairer on the poor and treats all people equally*.

7.1. Who should pay for minor, inexpensive illnesses (eg colds, aches, anxieties) Medicare or PHI?
7.2. Who should pay for moderately expensive illnesses (*eg, flu, high blood pressure, moderate depression*) the Medicare or PHI?
7.3. Who should pay for moderately serious illness illnesses (*eg, heart disease, respiratory disease, COPD, cancer)* Medicare or PHI?

Table 9a indicates the expected decrease in support for co-payments as the severity and expense of the illness rises. With serious, expensive illnesses, only four respondents (0.86 percent) supported co-payments with a score of 9 or 10. In contrast, 260 (55.8 percent) assigned a score of 0.00 or 1.0. Support for co-payments was equivocal when illness was described as minor and inexpensive.

A different pattern is revealed in Table 9b. For each category of illness, Medicare was the preferred source of finance but the preference was not strong and declined as the illness became *more* expensive and serious. The overall ambivalence is an accurate reflection of the divided support for PHI in Australia. The increasing preference for payment from PHI with severity contrasts with the de facto role of PHI as an institution for avoiding queues for minor conditions while leaving Medicare with the majority of the complex expensive treatments. The result possibly reflects irritation by some respondents that this is the case and the view that if PHI exists, then it should not avoid payment for expensive care.

Table 9a Results: preference for cost sharing

Question	Cost of service	(a)	Mean	(b)	Mean	SE	Diff	t
4.1	Minor	Patient	4.60	Medicare	5.40	0.154	-0.08	2.60
4.2	Moderate	Patient	3.45	Medicare	6.55	0.121	-3.10	12.81
4.3	Serious	Patient	1.79	Medicare	8.21	0.095	-6.42	33.78

Table 9b Results: who should pay: Medicare or PHI

Question	Cost of service	(a)	Mean	(b)	Mean	SE	Diff	t
5.1	Minor	Medicare	5.64	PHI	4.36	0.151	1.28	4.24
5.2	Moderate	Medicare	5.54	PHI	4.46	0.139	1.08	3.88
5.3	Serious	Medicare	5.27	PHI	4.73	0.168	0.54	1.61

4 Discussion and conclusions

An important conclusion from the study is that the form of questioning used – the Conflict Scale – produces plausible results which vary broadly in accordance with prior expectations. Respondents clearly distinguish between issues with mean scores varying from the middle of the scale to a maximum (mean) score of 8.21 and a minimum of 2.9. Despite ambivalence on a number of questions the results indicate strong preferences with respect to other questions. These are summarised in Box 3.

Box 3 Health system issues by strength of preference*

Choice	Difference in score (10 point scale)
Medicare pays for serious illness (not patient)	6.42
Quality of life – length of life	5.16
Choice of health scheme – not maximise anxiety	4.2
Doctor should make decisions (serious illness) - patient making decisions	4.16
Resources should be shared – should be used to maximise health	2.94
Equity of access – length of life)	2.46
Priority for suffering patients – priority to maximise health	1.96

*Scores represent the difference on the two 10 point scales. Two scores of 6.0 and 4.0 (necessarily summing to 10) would result in a score of 6-4 = 2.

Choice in the health sector is clearly important. Our respondents wished to select their own doctor and have the ability to influence the type of medical treatment they receive. However while wishing to have the right to choice, answers suggest that, consistent with the theory of supplier induced demand, most people would prefer doctors to make concrete decisions with the strength of the preference rising sharply as the severity of the illness increases. In sum, individuals wish to feel they have the possibility of some control via their choice of a doctor while not exercising it in subsequent serious decision making.

Results with respect to co-payments were unsurprising. While respondents did not feel strongly about co-payments in the context of inexpensive illnesses their acceptance of them evaporated with the severity of the condition, with virtually all respondents agreeing that Medicare should pay for serious expensive illnesses. In contrast, the results with respect to private health insurance conflicted with expectations. There was strong support for private health insurance but, contrary to what actually occurs in Australia, there was only a slightly increased preference for PHI payments when illnesses were serious and expensive. However this might reflect a negative, not positive, view of PHI by those who feel that, if it is to exist then it should not risk skim and provide only superficial services.

With respect to preferences for financing and decision making in Medicare the reality in Australia matches population preferences. Medicare does pay for serious illnesses and doctors do make the most important decisions. There is a partial correspondence between the Australian scheme

and the preference for a choice of health scheme although this theme was not pursued sufficiently to make stronger comments.

Some preferences are not realised. Large expenditures are devoted to lengthening life but expenditure to ensure quality of access either geographically or by socioeconomic status is relatively small. While there is aspirational support for the quality of life there are numerous examples in the health sector where quality is poor and suffering could be avoided (substandard care for oral and mental health are two important examples). In contrast with the stated preferences here, huge expenditures are devoted to marginal extensions to the length of life.

Public preferences, as reflected by our respondents, also contrast with the assumptions embodied in economic theory. The theory of supplier induced demand – better described as supplier regulated utilisation – still plays a minimal role in text book explanations of the health sector. QALY maximisation, broadly supported by economic theory and practice, contrasts with the preference for alleviating suffering rather than health improvement and sharing rather than health maximisation.

Appendix 1 Conflict Scale

MONASH University

Centre for Health Economics
Faculty of Business and Economics

Conflict of Values Survey *(v10)*

Dear Respondent

We are seeking your help with a Monash University Research Project which concerns values and what people are prepared to trade to achieve them.

We want you to think carefully when you read the questions, and answer according to your own values and what you consider to be important.

Thank you in advance for your assistance.

Prof Jeff Richardson	Dr John McKie	Angelo Iezzi
Foundation Director	Senior Research Fellow	Program Manager

If you wish to continue please press 'next'

Quota Questions

Are you:

- ❒ Male
- ❒ Female

Which age group do you belong to?

- ❒ 18-24
- ❒ 25-34
- ❒ 35-44
- ❒ 45-54
- ❒ 55-64
- ❒ 65+

What is your highest level of education (even if not finished)?

- ❒ High school
- ❒ Diploma or certificate or trade or TAFE
- ❒ University

Introduction

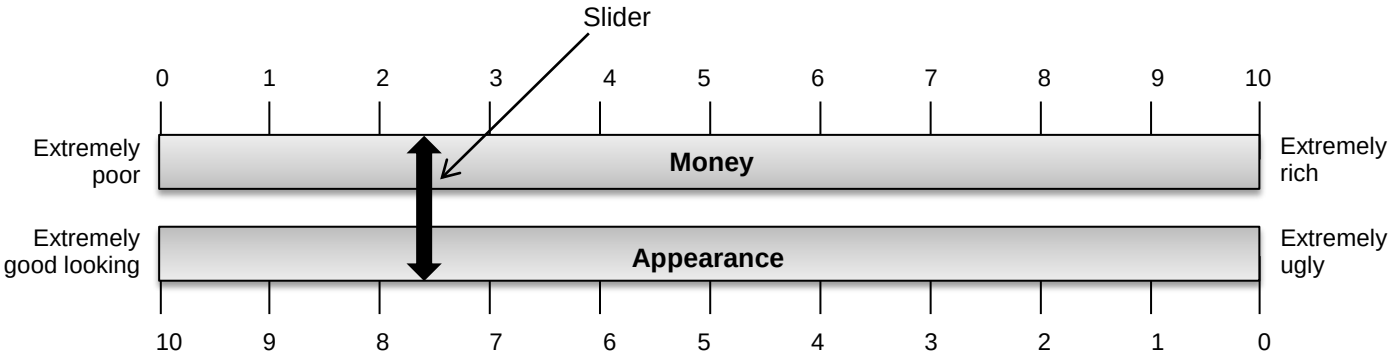
Sometimes our goals conflict with one another.

For example,

- Most people would like the government to cut taxes but also to provide more services
- And we would like to be slim but would like to eat more good food

Hence our survey has two scales. As you move the slider up one you cannot avoid moving down the other.

Example:



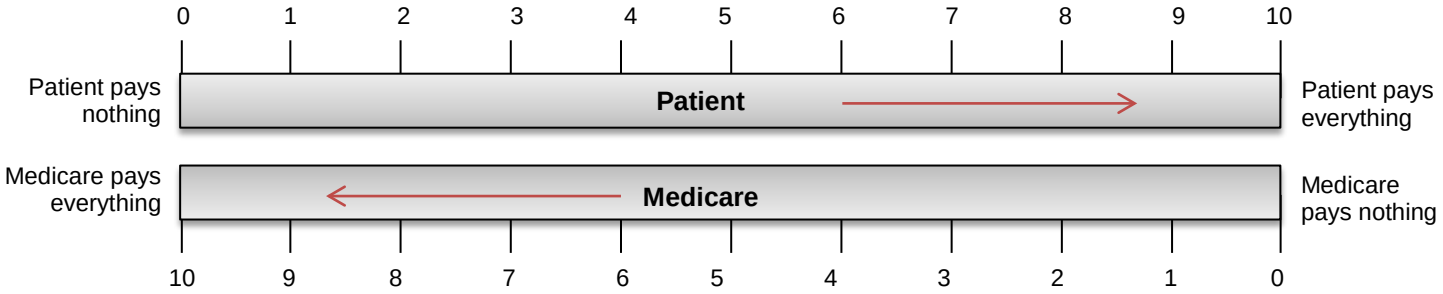
On the next pages, click on the slider and move it to your preferred position

Part A

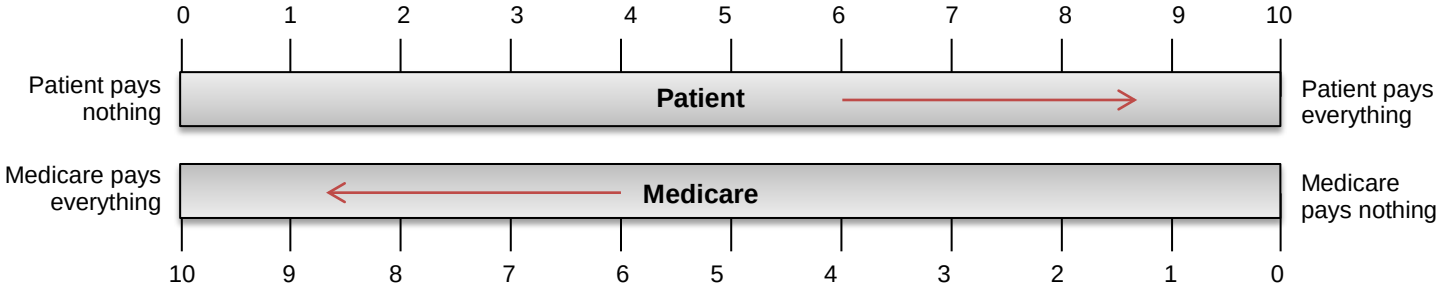
Who should pay for health care: Medicare or individual patients?

Some people argue that people should look after themselves.
Others argue that the cost of illness should be shared by everyone through taxation (ie Medicare).

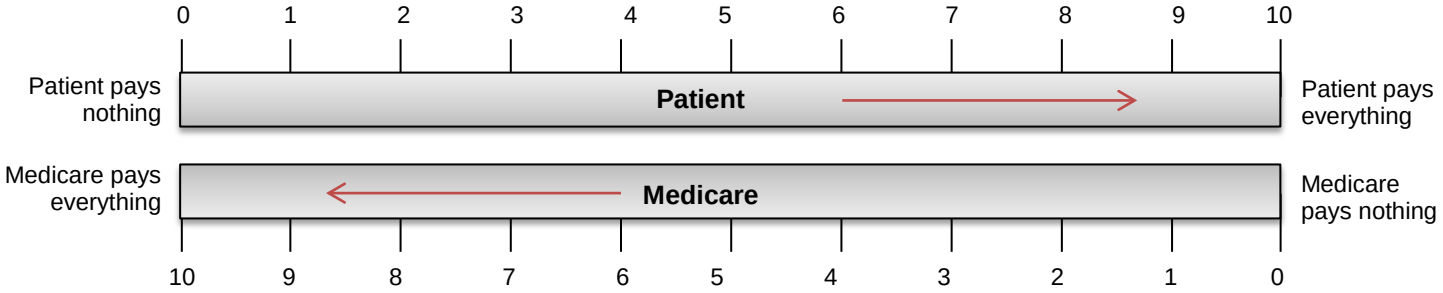
1. Who should pay for minor, inexpensive illnesses?
(eg colds, aches, anxieties)



2. Who should pay for moderately expensive illnesses?
(eg flu, high blood pressure, moderate depression)



3. Who should pay for serious, expensive illnesses?
(eg heart disease, respiratory disease, COPD, cancer)

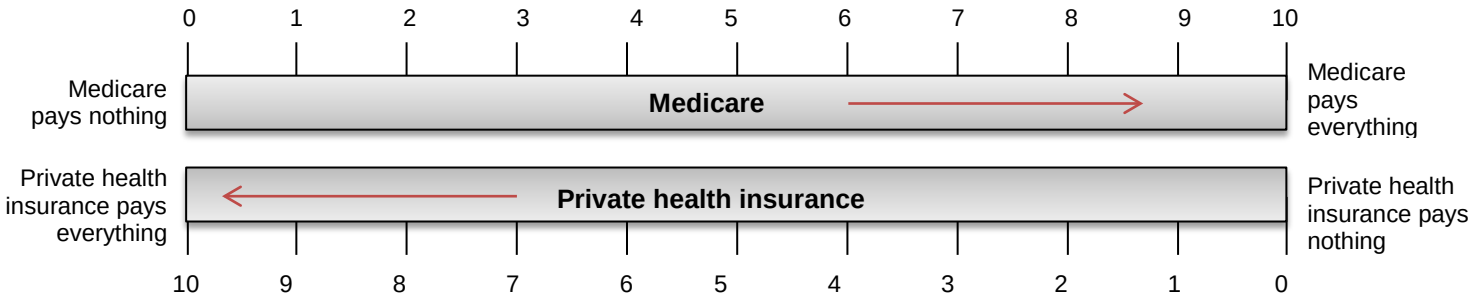


Part B

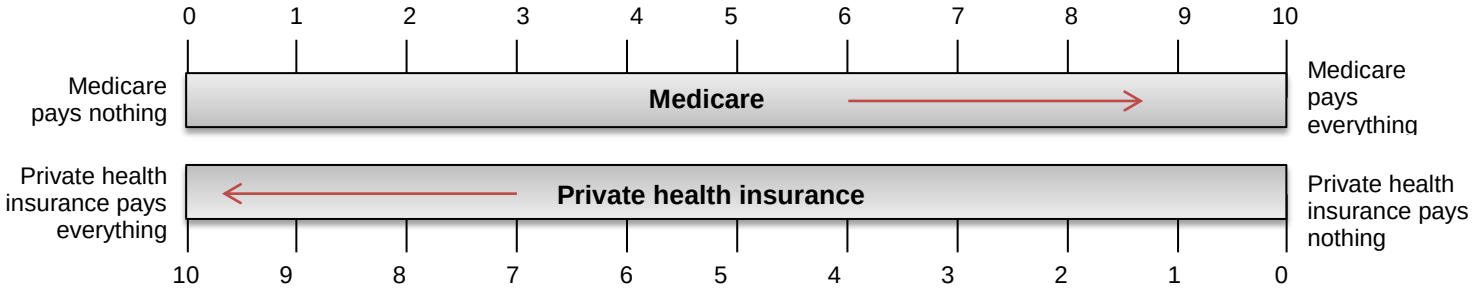
Who should pay for health care: Medicare or private health insurance?

Some people argue that private health insurance gives greater choice.
Others argue that taxation is fairer on the poor and treats all people equally.

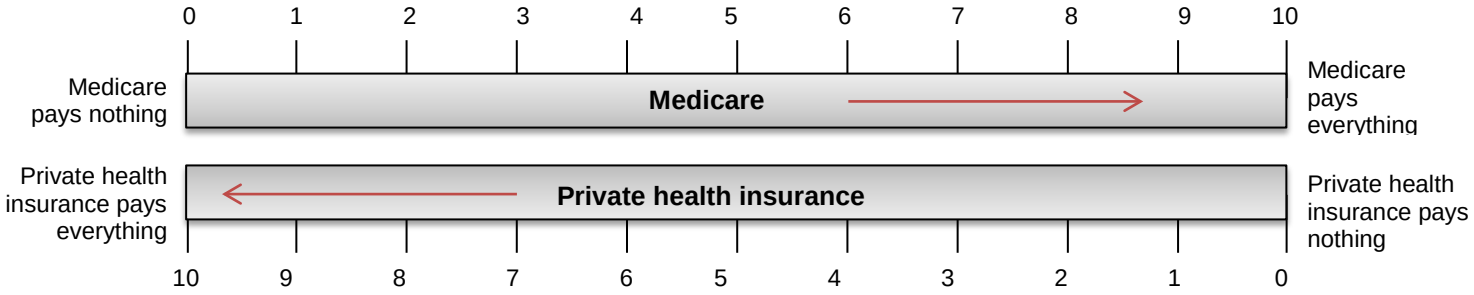
4. Who should pay for minor, inexpensive illnesses?
(eg colds, aches, anxieties)



5. Who should pay for moderately serious illnesses?
(eg flu, high blood pressure, moderate depression)



6. Who should pay for serious illnesses?
(eg heart disease, respiratory disease, COPD, cancer)

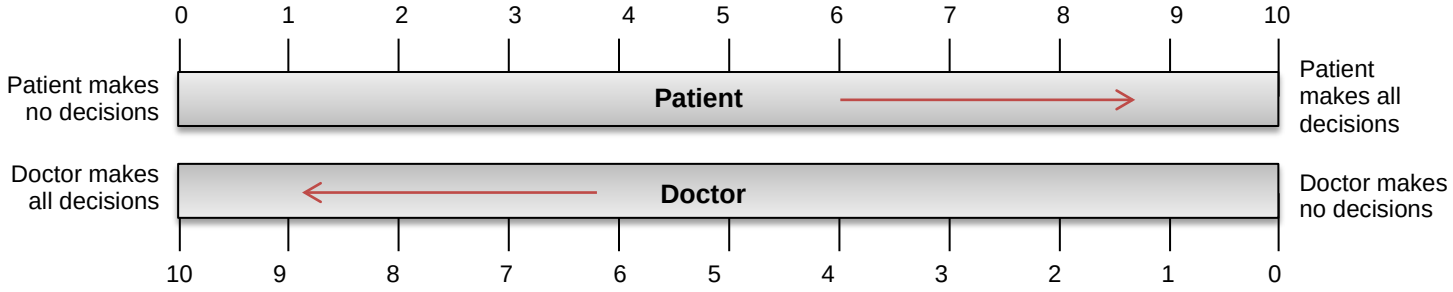


Part C

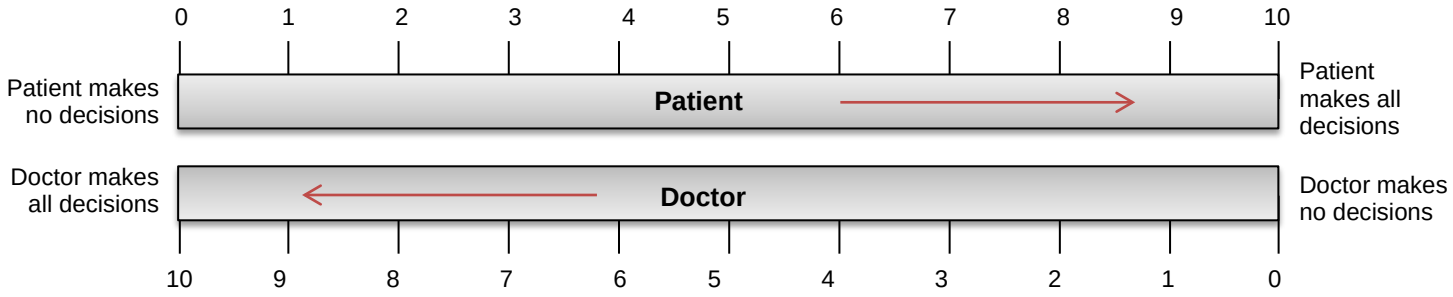
Who should make decisions about treatment?

Some people argue that doctors have better judgement and, therefore, doctors should make all treatment choices.
Others argue that patients should choose and doctors should only advise.

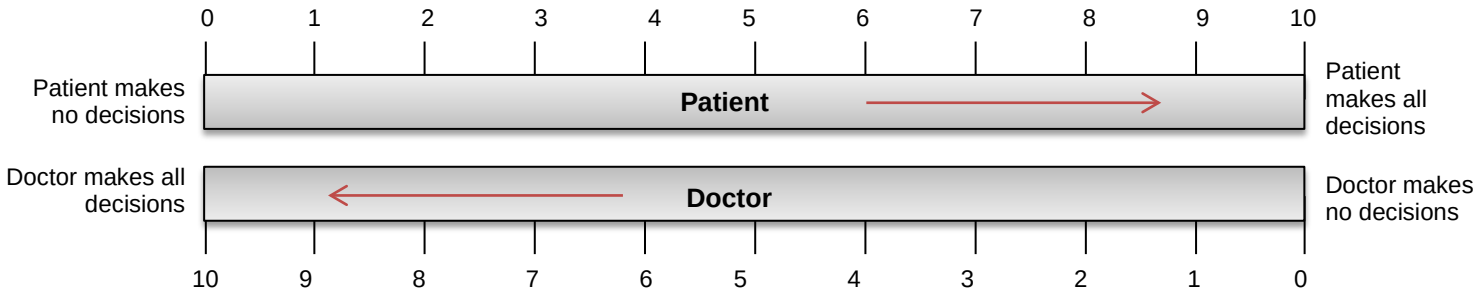
7. Who should make treatment decisions about minor illnesses?
(eg colds, aches, anxieties)



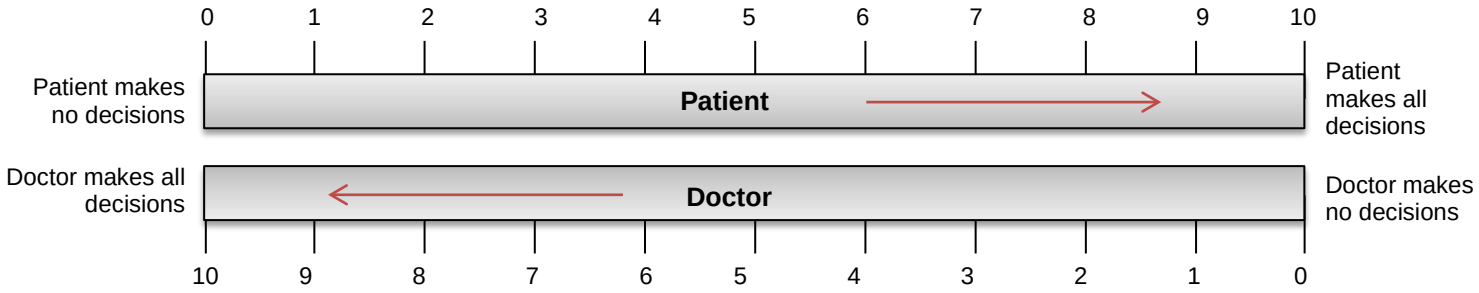
8. Who should make treatment decisions about moderately serious illnesses?
(eg flu, high blood pressure, moderate depression)



9. Who should make treatment decisions about serious illnesses?
(eg heart disease, respiratory disease, COPD, cancer)



10. Who should make treatment decisions about chronic ongoing illnesses? (eg asthma, diabetes, chronic depression)



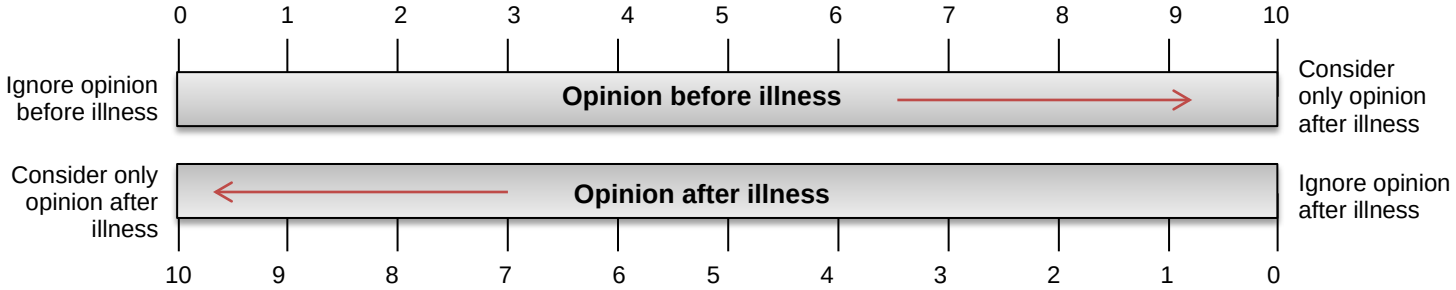
11. When should decision makers listen to people's opinions – before or after they have an illness?

People may feel fear, dread and anxiety before they have experienced an illness and therefore want comprehensive expensive care.

After they have experienced the illness they may find that the fear and dread were not fully justified.

The choice: Take account of people's opinions

- before an illness, allowing for their anxiety and errors.
- after they have the experience of the illness, and ignore anxiety and fear.



Part D

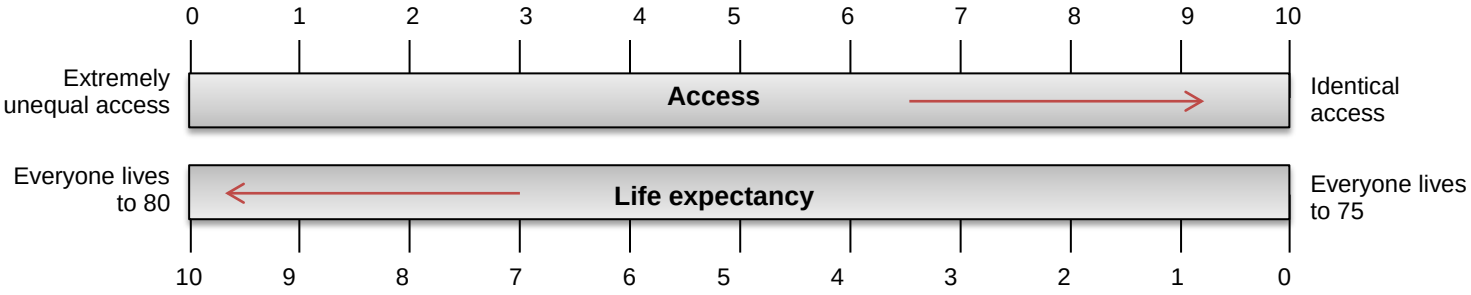
Aim of the health system

The health system has many possible goals:

- Maximising health (eg total years lived, no matter who gets them)
- Providing equal access to health care (eg the same queuing for services and travel time)
- Minimising suffering (improving quality of life for the very worst off)
- Reducing inequities of health between groups of people (rich/poor/aboriginals/city/rural)

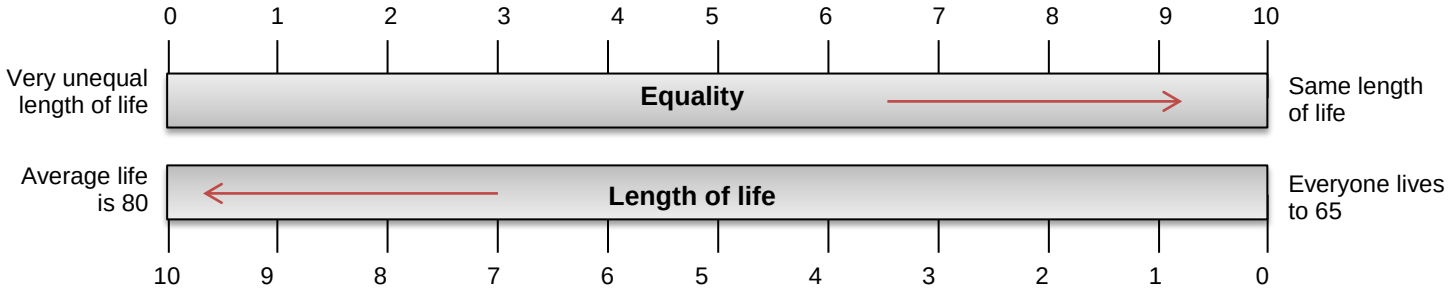
12. Which is important:

    Equal (fair) access to health services (waiting times)
    or
    Providing identical access to health services may stretch resources so far that the quality of services falls and life expectancy falls



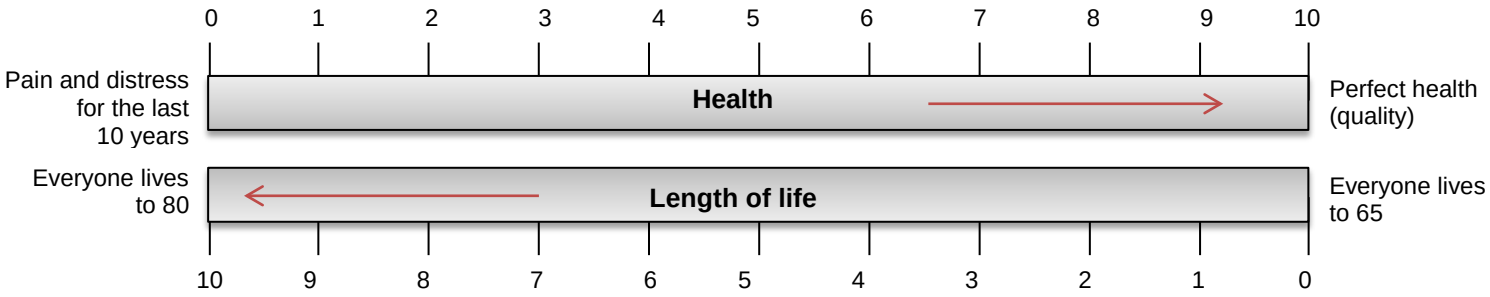
13. What should Medicare's policy be:

    Equal life expectancy
    or
    high average length of life. High average length of life means some live very long but others die when they are young.



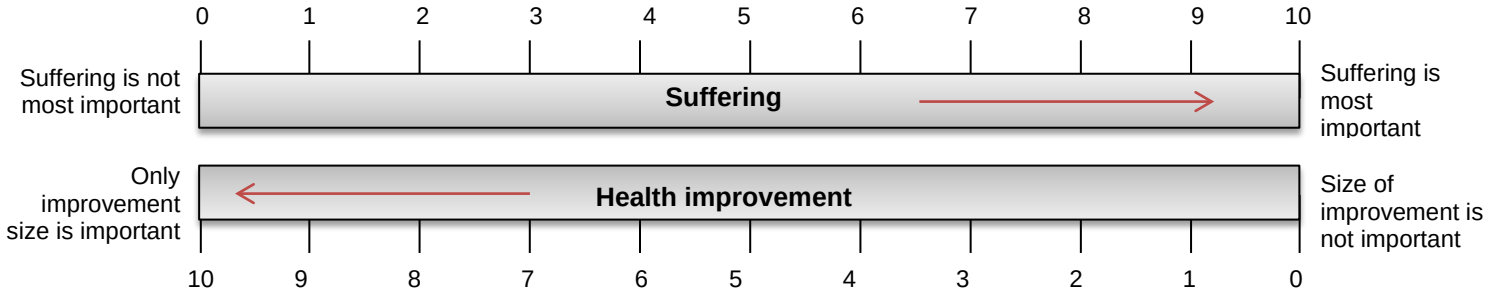
14. Which is more important:

Quality of life *or* Length of life



15. Which is more important:

Helping those who are suffering the most even if their health cannot be improved very much *or* Helping those whose health can be improved the most even if they are not suffering very much



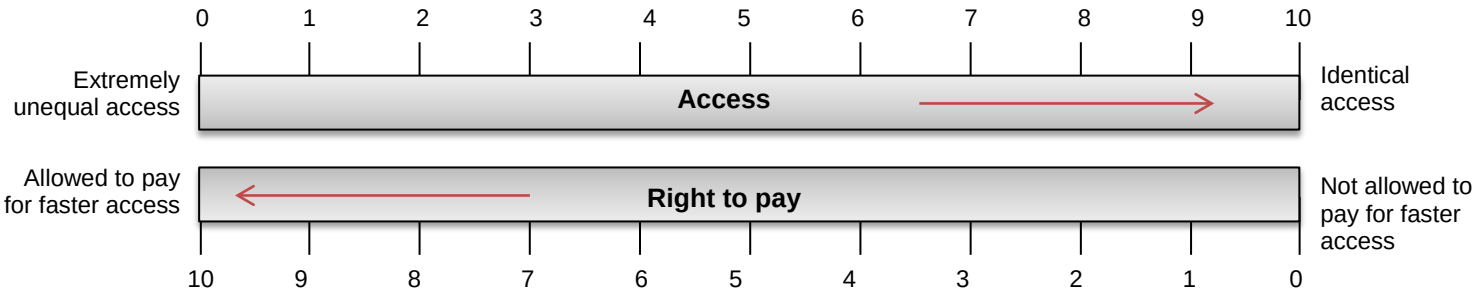
16. Which is more important:

Equal access *or* The right to pay for faster services

Some people argue that everyone should have equal access to health care and individuals should not be allowed to pay for faster access to services than others.

Others argue that people should have the right to spend their own money to get faster access. In this case, queues would vary according to individual spending.

Should people be allowed to pay to reduce their waiting time for health care?



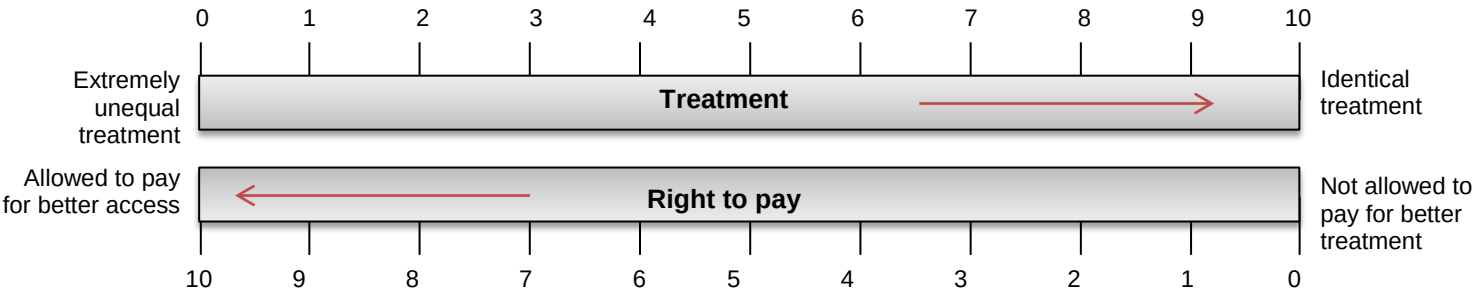
17. Which is more important:

Equal treatment for all *or* The right to pay for better health care?

Some people argue that everyone should have access to the same quality of care. Individuals should not be allowed to pay for better services than others.

Others argue that people should have the right to spend their own money to get better health care. In this case, treatment would vary according to individual spending.

Should people be allowed to pay for better health care?

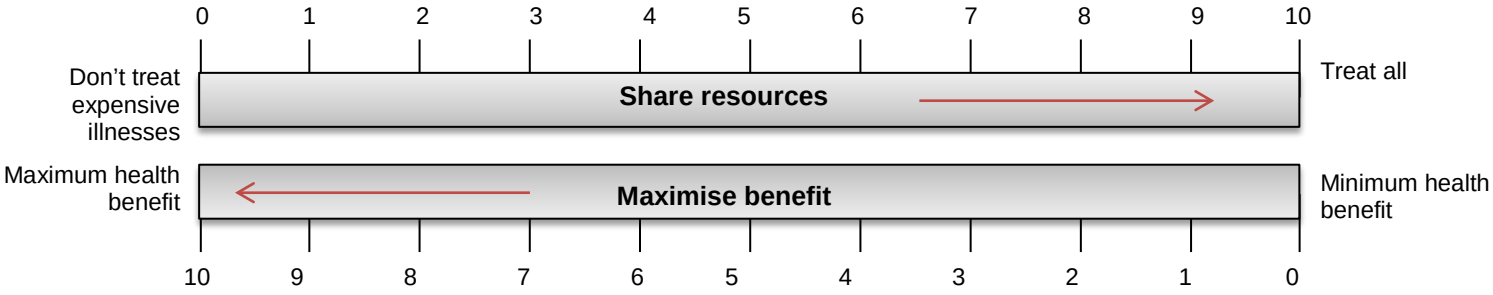


18. Sharing conflicts *vs* maximum global health

Some illnesses are expensive to treat. Money would buy more health if it was all spent on a smaller number of people who were not expensive to treat.

Extreme 1: We should share resources equally even when illness is expensive to treat and the budget will run out, no matter what the treatment cost.

Extreme 2: We should only spend money on patients who would gain the most even though others would miss out.



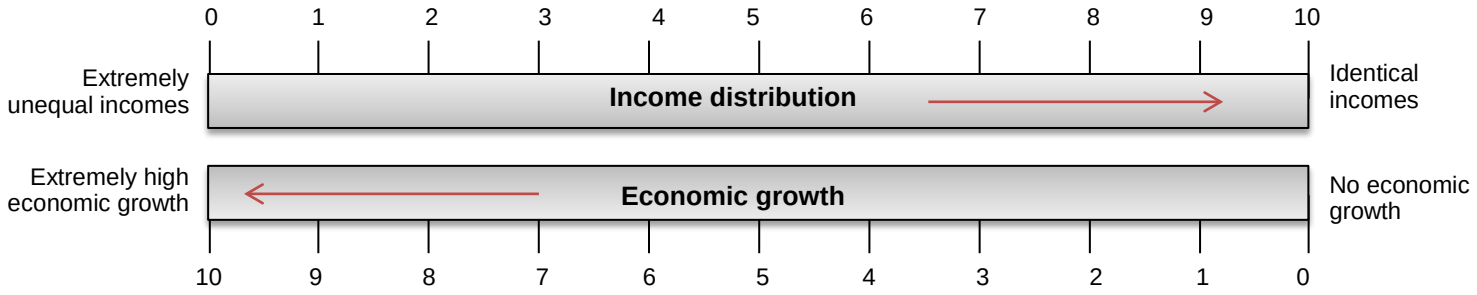
Part E

Social goals

19. Which is more important:

Economic growth *or* Distribution of income

Economic growth may be highest when individual incomes are very unequal



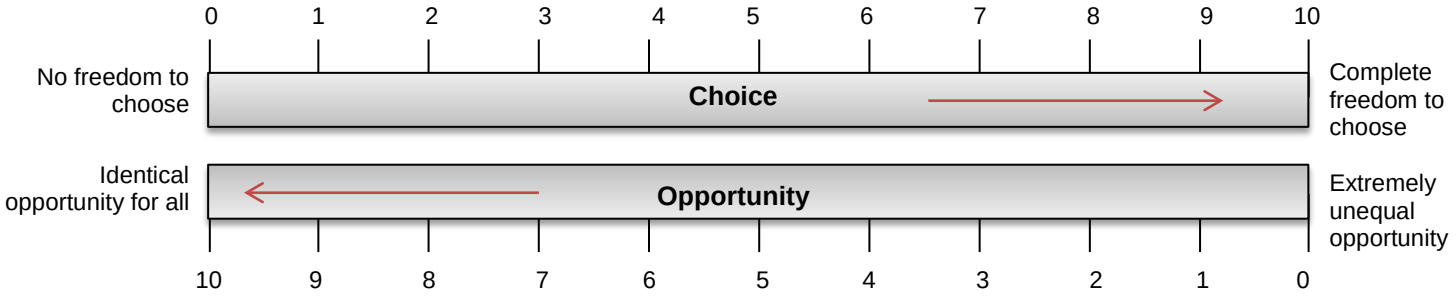
20. Which is more important:

Equal opportunity: no one starts behind or ahead *or* The freedom to choose

Equal opportunity may involve limiting some individuals' freedom to choose (eg, better than average education, health insurance).

It may mean unpopular taxes for funding schools and Medicare.

Freedom of choice may mean individuals make bad choices (eg failure to plan for ill health, catastrophes or retirement).

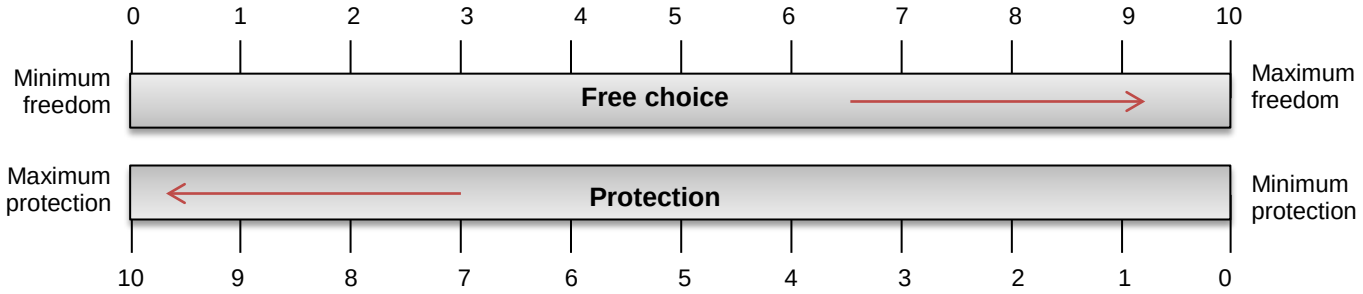


21. Which is more important:

Free choice *or* protection

Maximum freedom means others are free to exploit you and you may make wrong decisions.

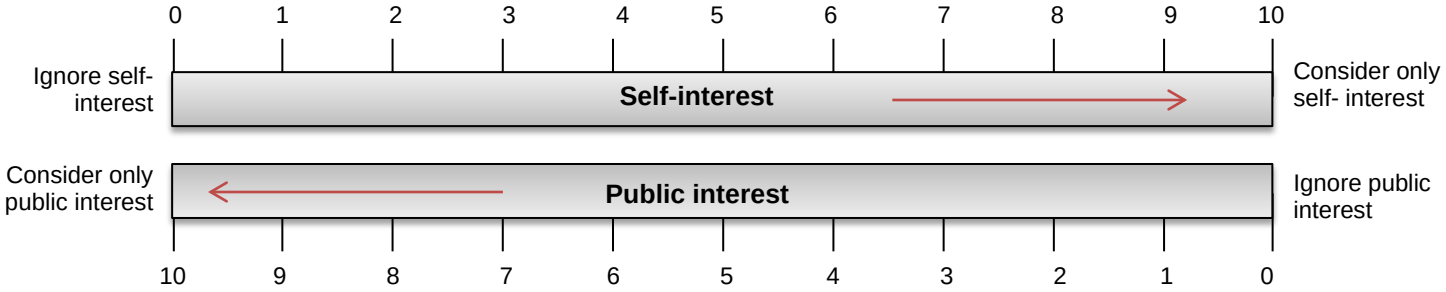
Maximum protection means restricted choice and control over much of your life by government.



22. Which was more important in the last election:

Self-interest *or* Public interest

When you thought about how to vote in the last election, how much did you think about self-interest and about what would be best for the country?



Part F

Happiness

Your happiness is often increased by your children, by helping others, by freedom of choice, etc. But there may be a limit after which these things make you less happy.

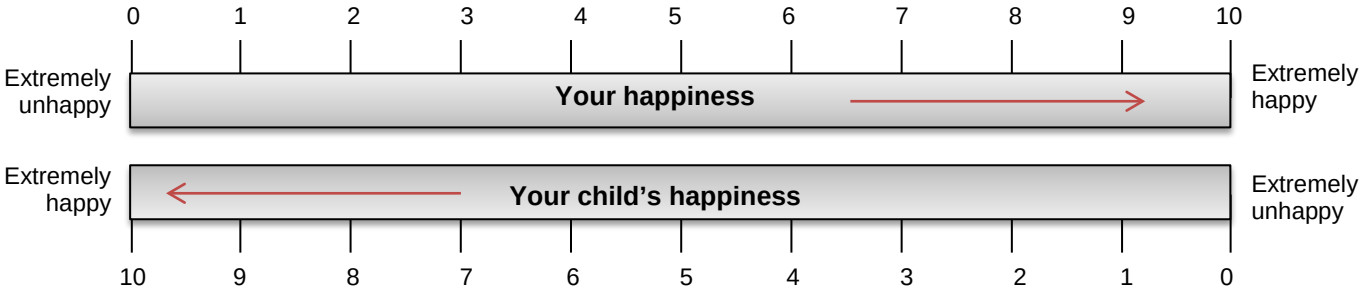
23. Which is more important:

Your happiness
or
Your child's happiness

(If you don't have any children, please imagine that you do have them)

You may have to sacrifice time, money, independence or your career to increase your child's lifelong happiness.

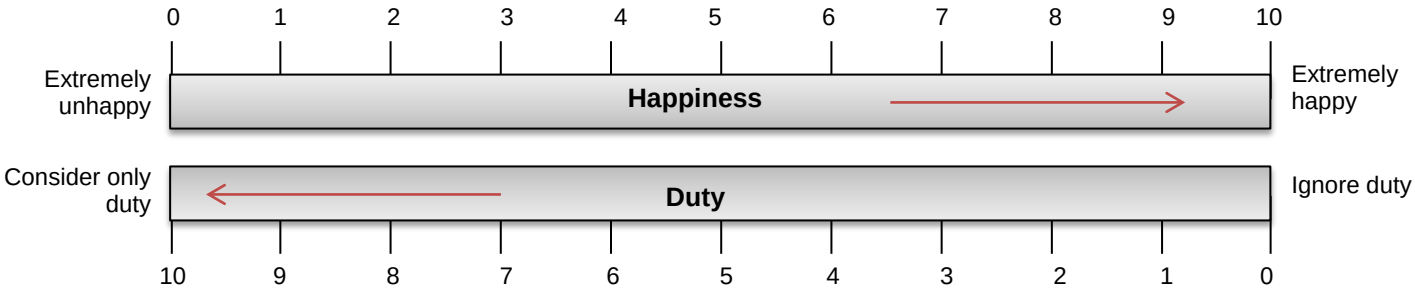
How important to you is your own happiness compared with your child's happiness?



24. Which is more important:

Your happiness
or
Your duty to others

Behaving in a socially good way (eg paying taxes, obeying laws, giving time and money to charity, helping people) may make you personally worse off.

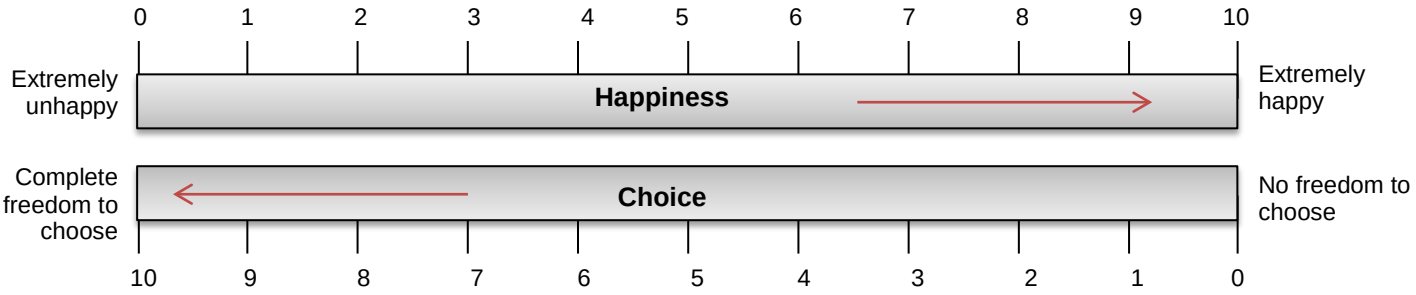


25. Which is more important:

Happiness
or
Freedom to choose

Sometimes choice allows us to be happy. At other times we make wrong choices. However, we may still value our right to make choices.

Would you prefer no freedom of choice, but complete happiness – every decision is made for you but so wisely that you could not be happier?
or
Would you prefer to be absolutely free to do whatever you wanted, when you always made the wrong choices and this made you miserable?

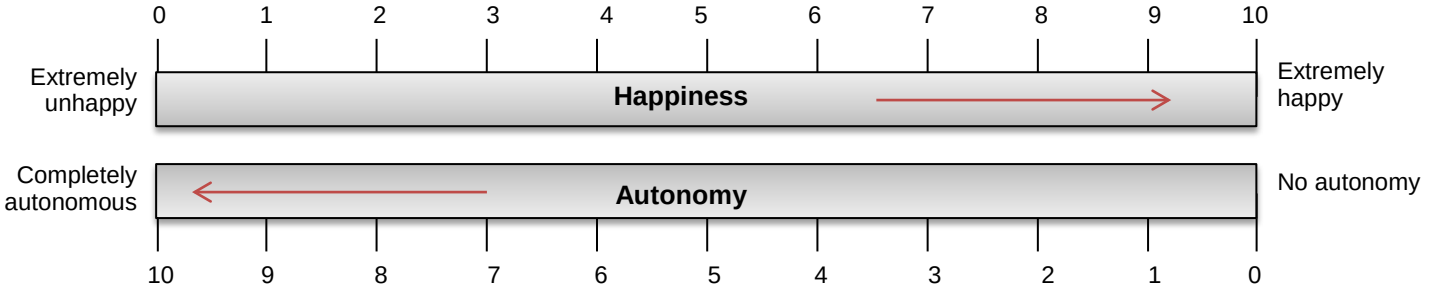


26. Which is more important:

Autonomy
or
Happiness

Autonomy means you are capable of doing what you want. You have the knowledge, skills and ability to achieve your goals.

Being autonomous may make you happy. However, having the ability to achieve things does not mean that you will achieve them. You may be lazy or frustrated by having to do everything and unhappy with yourself for not achieving your goals.



Part G

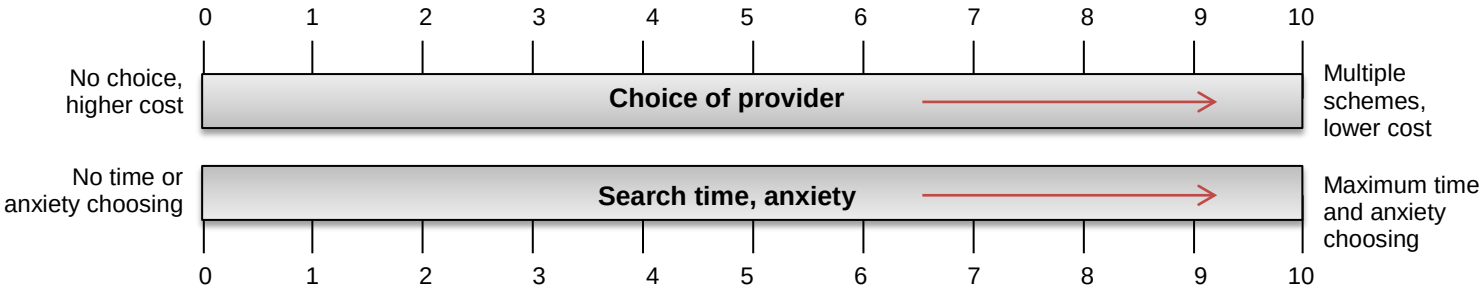
Choice

Choice puts you in control of what happens to you.
It may result in better outcomes for you.

However you may face too many choices which are complex so you make mistakes. This may make you anxious about making choices.

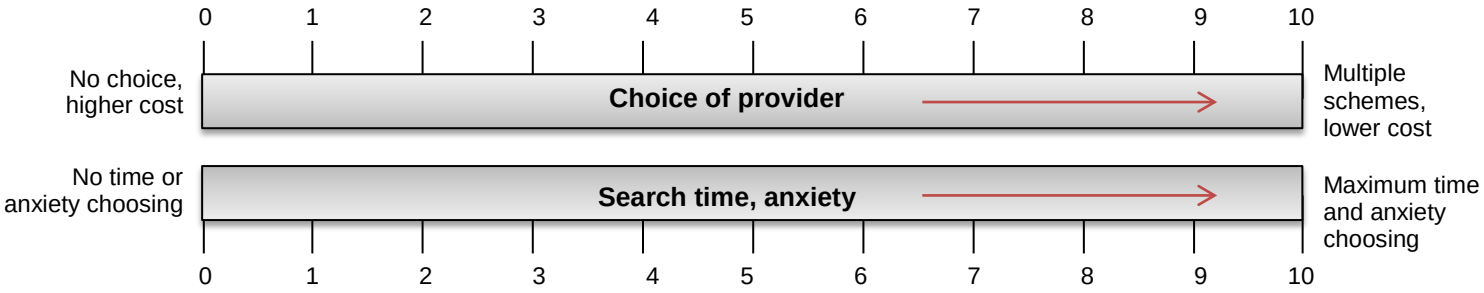
27. Choice of provider: electricity, gas, water, telephone
Which is important:

Maximum choice: you select a scheme which suits you from multiple schemes and multiple providers
or
No time or anxiety over choice – single provider, services cost slightly more.



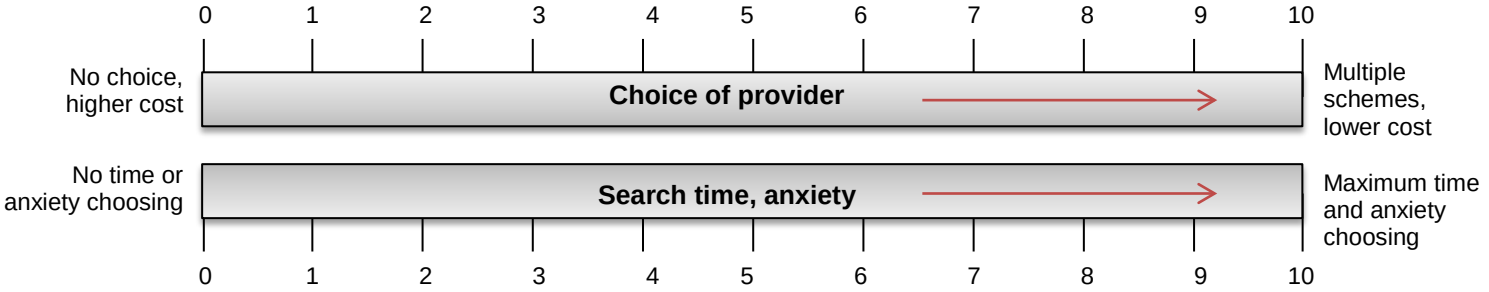
28. Financial choices
Which is more important:

Maximum choice: Multiple banks, investment and superannuation funds and life insurance
or
No time or anxiety over choice - Single provider, services cost slightly more



29. Financial cost of health care (if Medicare did not exist)
Which is more important:

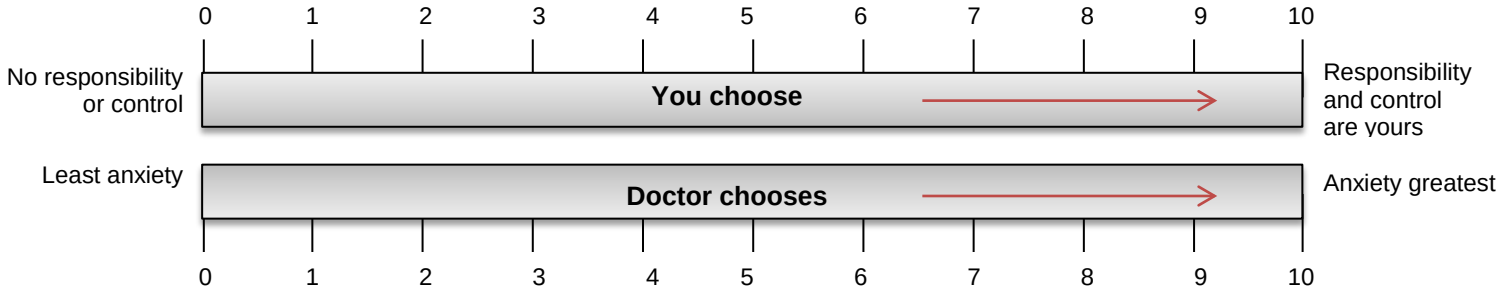
Maximum choice: multiple schemes with different levels of cover; less cover (you pay more when sick) means a lower cost insurance
or
No time or anxiety over choice - fixed cover, fixed cost



30. Choice of medical treatment

Control events *or* Reduce anxiety

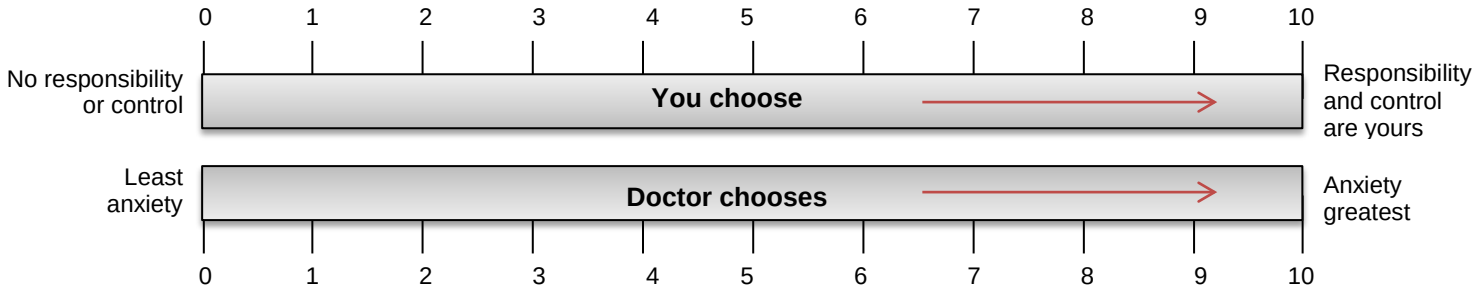
Sometimes alternative treatments are available (eg drug, radiotherapy, surgery). It is often unclear which treatment is best choice.



31. Choice of drugs

Control events *or* Reduce anxiety

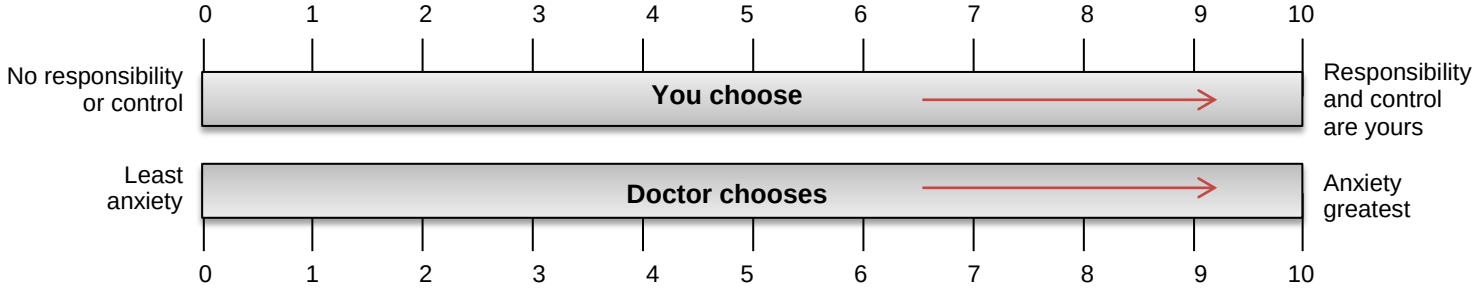
Different drugs have different side effects. Choice may cause anxiety if the choice is difficult and important



32. Choice of hospital/doctor

Control events *or* reduce anxiety

Suppose you were allowed to select your own doctor to carry out an operation

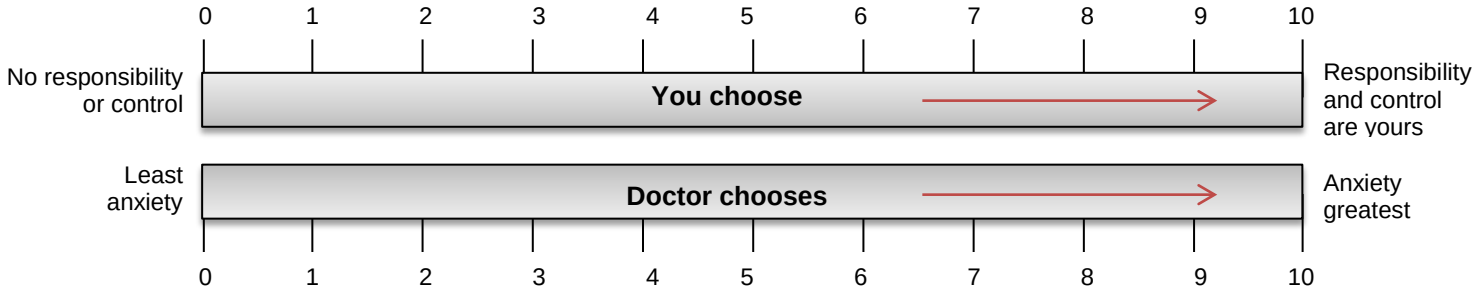


33. Choice of quality of care

Control events *or* Reduce anxiety

Suppose you could buy more or less care or pay a fixed price and let the doctor select the type of care you get.

Buying care means you can pay less than the fixed price or pay more and possibly get better care.



34. Who would you prefer in government

- ❒ Labor
- ❒ Liberal/National
- ❒ Greens

35. What is your postcode? …….

36. Are you

- ❒ Married or living with a partner
- ❒ Single: never married
- ❒ Single: widowed
- ❒ Single: divorced or separated
- ❒ No answer

37. Do you have children?

- ❒ Yes
- ❒ No

38 Child = yes then

How many children do you have?

- ❒ 1
- ❒ 2
- ❒ 3
- ❒ More than 3

39. What is your cultural background? (Select one answer only)

- ❒ Aboriginal/Torres Strait Islander
- ❒ Anglo-Saxon
- ❒ Asian
- ❒ European
- ❒ Pacific Islander
- ❒ Latin American
- ❒ Maori
- ❒ African
- ❒ South Asian (India/Bangladesh, Pakistan, Sri Lanka etc)
- ❒ Middle Eastern
- ❒ Other: …….

40. Religion:

- ❒ Christianity
- ❒ Judaism
- ❒ Islam
- ❒ Hinduism
- ❒ Buddhism
- ❒ No religion
- ❒ Other: …….

If 40 = Christianity then:

41. Church *Which Christian church do you belong to?

- ❒ Anglican
- ❒ Roman Catholic
- ❒ Orthodox
- ❒ Protestant
- ❒ Other: …….

42. Do you follow the teachings of your religion?

- ❒ It plays a major role in my life
- ❒ It plays a somewhat major role in my life
- ❒ It plays a somewhat minor role in my life
- ❒ It plays a minor role in my life
- ❒ It plays an insignificant role in my life

References

Richardson, J., A. Maxwell, et al. (2012). The Myth of Maximisation: Quantifying trade-offs between social objectives using the Conflict Scale, Research Paper 74. Melbourne, Centre for Health Economics, Monash University.