

EQUITY IN HEALTH AND HEALTHCARE

VIEWS FROM ETHICS, ECONOMICS AND POLITICAL SCIENCE
PROCEEDINGS FROM A MEETING OF THE HEALTH EQUITY NETWORK

Edited by Adam Oliver



The Nuffield Trust
FOR RESEARCH AND POLICY
STUDIES IN HEALTH SERVICES

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THE CONTRIBUTORS

Alastair Campbell is Professor of Ethics in Medicine at the University of Bristol.

E-mail: alastair.campbell@bristol.ac.uk

Raanan Gillon is Professor of Medical Ethics at Imperial College, London:

E-mail: r.gillon@ic.ac.uk

Julian Le Grand is Richard Titmuss Professor of Social Policy at the London School of Economics and Political Science. *E-mail: j.legrand@lse.ac.uk*

Hugh Gravelle is Professor of Economics at the University of York. *E-mail: hg8@york.ac.uk*

Stephen Harrison is Professor of Social Policy at the University of Manchester.

E-mail: s.r.harrison@man.ac.uk

Rudolf Klein is Visiting Professor at the London School of Economics and Political Science.

E-mail: Rudolfklein30@aol.com

Adam Oliver is Research Fellow and Lecturer in Health Economics and Policy at the London School of Economics and Political Science. *E-mail: a.j.oliver@lse.ac.uk*

Tom Sorell is Professor of Philosophy at the University of Essex.

E-mail: tsorell@essex.ac.uk

Simon Stevens is The Prime Minister's Health Policy Adviser, at No. 10 Downing Street.

E-mail: SStevens@no10.x.gsi.gov.uk

Albert Weale is Professor of Government at the University of Essex.

E-mail: weala@essex.ac.uk

Alan Williams is quasi-retired Professor of Economics at the University of York.

E-mail: ahw1@york.ac.uk

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INTRODUCTION

Adam Oliver

London School of Economics and Political Science

Background

How *ought* we act? How *do* we act, and why do we act in the ways that we do? And what are the implications (e.g. the costs and consequences) of acting both in the ways we ought, and in the ways we do? These normative and descriptive questions, which very broadly fall within the domains of moral philosophy, political science and economics, respectively, are integral not just to policies that impinge upon health equity, but to all policies (and, indeed, to life in general). They are questions that interest me, and since establishing the Health Equity Network (HEN: www.ukhen.org.uk), they are questions that I have felt ought to be addressed exclusively within one of the HEN seminars.

In February 2002 I contacted most of the contributors to these proceedings to solicit their views on whether and how such a seminar should be organised. An idea initially forthcoming from Alan Williams was that we could invite papers from an ethicist, an economist and a political scientist, and then have each author have his work discussed by representatives from each of the other disciplines. That is, the ethicist would have his paper discussed by a political scientist and an economist, the economist by an ethicist and a political scientist, and the political scientist by an ethicist and an economist. This idea was accepted and pursued, and Tom Sorell, Julian Le Grand and Albert Weale were invited to write short papers from their perspectives as an ethicist, an economist and a political scientist, respectively.

The authors' remit was very general: they were merely requested that their papers should in some way relate to equity in health and/or health care. Stephen Harrison and Alan Williams commented on Sorell's paper, Alastair Campbell and Rudolf Klein on Le Grand's paper and Raanan Gillon and Hugh Gravelle on Weale's paper. The main papers and the written

commentaries from the discussants are contained within these proceedings. I do not propose to summarise the arguments contained within them in this introduction. The papers are short, and the interested reader is recommended to take the time to read the papers – and draw their own interpretations – themselves. But it is interesting to note that many of the papers either directly or indirectly consider the notion of patient choice.

Patient choice is a topical concept and is intrinsic to considerations of equity. After all, the extent to which different individuals or groups are allowed to exercise choice may largely determine who gets what, and when. It is possible that allowing greater patient choice in a resource-constrained health care system will have both good and bad implications. We have no real way of knowing whether the good will outweigh the bad or vice-versa; we can merely speculate (and hope to accumulate).

We could speculate that, even though some people may be naturally more adept at taking advantage of more choice than others, allowing greater choice generally would lead to greater advantages for everybody than would have otherwise been the case, as everybody would be able to reap *some* benefits from greater choice. In these circumstances, greater inequalities in, for example, access, utilisation and/or outcomes may arise. Some may perceive nothing wrong with greater inequalities if everybody benefits; others may be averse to inequalities to such an extent that they would prefer greater equality even if everybody (including the worst off) benefited less as a result. In other words, those who hold the former view would place greater emphasis on efficiency, and those who hold the latter view would place a greater emphasis on equality, in this hypothetical efficiency-equality trade-off. For many (including myself) it is difficult to fully accept a call for greater equality if, as a result, we know for certain that the worst off in society would be even more worse off as a consequence. Thus, for many, allowing more choice is likely to seem less attractive if such a policy ultimately harms those who are worst off.

And we can speculate that it might. As Klein intimates towards the end of his commentary, allowing more choice could be costly. For example, with greater choice, people may demand longer consultation times, and/or greater use of the latest, most expensive (although not always incrementally more effective) pharmaceuticals and medical technologies, and providers may be under increasing pressure to provide these services. If the better educated and wealthier sub-groups in society are more aware of the choices they are being offered, it is possible that – in a resource constrained system – resources will be increasingly redirected to the provider units that tend to serve these particular patients. Of course, regulation can limit or even eliminate the chances of these events occurring, but if we find that extensive regulation to guard against the ill effects of greater choice is necessary, is it really worth introducing more choice in the first place?¹

Thus, we can speculate to opposing effects, but the power to convince may often depend upon the quality of the speculation. If nothing else, the papers offered in these proceedings are of high quality.

1. Save for its role as a 'political' offering to a general electorate hungry to hear that their preferences are being met (even if for many, in reality, they are not).

The seminar

The seminar was held at the King's Fund in London on November 11th 2002, and was split into four sessions. The main papers written from the perspectives of ethics, economics and political science were respectively discussed in the first, second and third sessions. In the fourth session, Simon Stevens, The Prime Minister's Health Policy Adviser at No. 10 Downing Street, concluded with his thoughts on the day.

The programme for the seminar and a list of those in attendance are given in the Appendix. The main papers and the written commentaries from the discussants are included in these proceedings in the order in which they appear in the programme. At the end of the proceedings, after reflecting upon the preceding papers, Stevens offers some considered opinions on the (dynamic) relationship between equity and choice in the UK National Health Service.

Acknowledgements

I am very grateful to the contributors to these proceedings, and to the chairpersons at the seminar – Charles Normand, Tony Culyer and Alastair Gray – who all gave their time for no tangible benefit. The seminar was sponsored by the Economic and Social Research Council (award number R451265135), and I am also grateful to the King's Fund, through the offices of John Appleby and Kim Stirling, for hosting the event. I thank the Nuffield Trust for publishing the proceedings and, finally, I thank David McDaid, without whom the Health Equity Network wouldn't be a network.

APPENDIX

Programme

09.30-10.45: **The ethics perspective**

Chair: *Charles Normand, London School of Hygiene*

Author: *Tom Sorell, University of Essex*

Discussants: *Stephen Harrison, University of Manchester*

Alan Williams, University of York

11.15-12.30: **The economics perspective**

Chair: *Tony Culyer, University of York*

Author: *Julian Le Grand, London School of Economics*

Discussants: *Alastair Campbell, University of Bristol*

Rudolf Klein, London School of Economics

1.30-2.45: **The political science perspective**

Chair: *Alastair Gray, Oxford University*

Author: *Albert Weale, University of Essex*

Discussants: *Raanan Gillon, Imperial College*

Hugh Gravelle, University of York

3.15-4.00: **Comment**

Simon Stevens, Number 10 Downing Street

Attendees:

Pauline Allen	Paul Dolan	Martin Hewitt	Monica Oliveira
Steven Allender	Bernard Dowling	Michael Hughes	Adam Oliver
John Appleby	Emily Fargher	Sheila Jones	Katherine Payne
Nigel Armstrong	Christine Ferris	Rudolf Klein	Sue Povall
Ruth Barnes	Debbie Fox	Bruce Laurence	Rosalind Raine
Evan Bates	Martin Gajos	Hugh Lee	Tracey Sach
John Beal	Raanan Gillon	Miaw-Chwen Lee	Louise Sarch
David Braunholtz	Hugh Gravelle	Julian Le Grand	Alex Scott-Samuel
Jacqueline Brown	Alastair Gray	Richard Little	Jane Sandall
Jilla Burgess-Allen	Diane Gray	Joanne Lord	Paul Seymour
Sara Burke	Colin Green	Alan Lovell	Tom Sorell
Alastair Campbell	Ulla Gustafsson	Anne Marciniak	Iliyan Stefanov
Roy Carr-Hill	Erica Haines	Roger McCarthy	Simon Stevens
Paula Cooper	Barbara Hanratty	David McDaid	Sylvia Thompson
Peter Cosgrove	Nancy Harding	Ali McGuire	Christine Tillsley
John Coss	Stephen Harrison	Jerry Morris	Aki Tsuchiya
Tony Culyer	Andreas Hasman	Susan Murray	Albert Weale
Linda Davies	Andrew Healey	Sarah Nettleton	Alan Williams
Chris Dibben	Stephen Heasell	Charles Normand	

HEALTH CARE PROVISION AND PUBLIC MORALITY: AN ETHICS PERSPECTIVE

Tom Sorell
University of Essex

The task of improving the health service in the UK is dogged by what I shall call the ‘two time-scales problem’. One time-scale is that of a parliamentary electoral cycle: five years. The other is the time-scale required to remedy what are currently huge shortages of personnel and modern facilities and equipment: say, twenty years. The two time-scales problem leads ministers and members of parliament (MPs) into a temptation that is central to the ethics of public-office holding. On the one hand, politicians are constrained to think up achievements deliverable in five years and deliver them. On the other hand, success in delivering them is often partial, and achievements deliverable in five years are often minor, or tied to targets that do not necessarily involve much of a health gain for many patients. Even where the achievements are not questionable, they can seem insignificant to voters, or can be given less weight by voters than inchoate impressions of a health care system unable to cope. Above all, a single parliamentary term is unlikely to produce visible and durable progress with the long-term problems of the NHS. The temptation for politicians is to concentrate on the small, deliverable achievements, and to direct money in an ad hoc manner to achieve them at the right time in the electoral cycle, and in the right constituencies, even if to do so is to divert money from where it would do most good.¹ The temptation is also to present the deliverable achievements as bigger than they are, or more of a step toward a long-term solution than they are. For example, there is a temptation, sometimes succumbed to, to manipulate waiting list statistics, or to give numbers for

1. I am not claiming that measures for the long-term are never adopted by governments, even when the benefits will be reaped by their political opponents. I am claiming that there is a temptation to make the most, and often too much, of what can be achieved in the short term.

recruitment to nursing or medicine that are selective or one-sided. Since many problems confronting the UK and other governments are long-term and expensive, the two time-scales problem, with its temptations to deception and opportunism, is not peculiar to health care.

The two time-scales problem might be less severe if the electoral cycle were closer in length to the time-scale required to solve large public problems. Although this would give governments and officials longer to solve problems that take a long time to solve, it might also encourage sloth or complacency in the more extended periods between elections, or even permit wrong turns to be taken for longer during an electoral term, so that things became worse than during a five-year period of office. Another possibility would be for the electoral cycle to be kept to its present length or made only slightly longer, but with different and less manipulable measures of progress to govern the perception of government achievement. This might come about if, say, the Audit Commission worked out the measures and also controlled the monitoring of performance. Most experts agree that the familiar measures of numbers of people on a waiting list, or length of waiting times, vary in significance according to the condition of a patient and the effectiveness of a treatment. A would-be custodian of measures would take this into account. Such a body would probably devise some measures that are not included at all in current political give-and-take, but that are appropriate to a twenty-year long onslaught on the problems of the health service. It is possible that the Wanless Report has contributed to this process in relation to the long-term plans for the health service of the present Government.

Whatever there is to be said for these approaches to the two timescales problem,² they leave out something of huge importance: the public, and the moral part they will have to play if fair measures of progress with health care are to be judged fairly against government performance, and if the size of the task of the government is itself not to be larger than it needs to be. The public will need to think longer term, and to make use of available information about options facing any government; they will need to be patient if the problems are long-term, and willing to pay more if the solutions are monumentally expensive. They will need to do these things as electors or citizens. They will need to do further things as patients within the NHS. For, as is increasingly being recognised, not all demand on NHS services, especially GP services, is reasonable demand. If a third of GP visits are for minor ailments that require non-prescription medication or that doctors cannot really help with, then there may be an obligation on members of the public not to present if they know they have those conditions. Or at least there may be an obligation to take seriously the idea that not all symptoms require GP time. Again, if there is a prevalence of diseases preventable and known to be preventable by non-demanding exercise, an implementable diet, or a nicotine substitute for cigarettes, there may be a moral obligation on patients to try those things in response to GP advice, or in response to public health information.³

In a different country, these different obligations might be grounded philosophically on the

2. For scepticism about the usefulness of audit techniques in the UK public sector, see Onora O'Neill's Reith Lectures (O'Neill, 2002).

3. The general question of what moral responsibilities patients have, and how these fit into medical ethics, is taken up in Draper and Sorell (2002).

ethics attached to the roles of citizen and patient respectively, but because of the way the NHS functions in the UK not only as a source of medical treatment but as a prime medium of national solidarity and national identity, it will not do to take the two roles apart. Here no-one is a patient, doctor or nurse *tout court*. Instead, users and providers of health care have an irreducibly civic identity as well. In earlier work on a related subject, I talked of the citizen-patient and the citizen-doctor, with a hyphen, to indicate the fusion of citizenship with health care roles in the UK (Sorell, 2001). The fact that the NHS continues to play a special role in national consciousness means that in the real world, and not just ideally, the obligations that people have to it stand a chance of being acknowledged and acted upon.

It is the obligations of the citizen-patient and the small gifts of co-operation that can reasonably be expected of the citizen-patient that I mainly have in mind when I talk of public morality in relation to the provision of health care in the UK. No doubt there are obligations that public office-holders – ministers, officials, health authority workers etc. – also contribute to the bigger scheme of public morality in relation to health care, but these are much more widely discussed than the ones I want to consider. No-one who has lived in the UK since 1997 can be unaware of the moral dangers associated with excesses of spin in relation to health care spending plans, or in progress on recruitment or building programmes, or in relation to particular patients who have been failed by GPs, consultants, health authorities and others. The transgressions of *patients* are less well known. Except in publicity campaigns exposing and condemning the growing number of assaults on hospital staff and ambulance personnel by (usually drunken) patients, the idea that patients can do wrong is unfamiliar. Patients can be and are guilty of wrongdoing. But, as will emerge, public morality arguably requires them to do more than *refrain* from wrongdoing. There are positive things they can do for themselves and for the NHS.

The consumerism of the Tory health service reorganisation and its continuation under Labour have not helped people to recognise the part they may have to play. The catchphrase that the customer is king or that the customer is always right is out of its element in a national health service like the UK's, if it means that, other things being equal, the patient's preferences should be met down to the last detail.⁴ Not only can the customer-patient's preferences be medically questionable; but even where they are not, they need to be satisfied alongside other medically reasonable preferences in a context of scarcity. These facts do not mean that patient preferences shouldn't be given weight and satisfied when no-one is disadvantaged by doing so: there is probably a lot of reasonable patient choice that has never been adequately catered for in the NHS and that would not be unreasonably expensive to act upon. The point is that that patients' demands are not *always* reasonable. Demands can be unreasonable relative to the many inevitable constraints on the distribution of expensive health care goods and services. Under the convention that the customer is king, the category of unreasonable demand is either held to be vacant or to allow for anything that a seller is willing to tolerate. It is, however, doubtful that the patient/consumer has ever been elevated to the status of king. Nonetheless, it is widely accepted that there are many patient's expectations that need to be met by health care workers, but fewer health care workers' expectations that need to be met by patients.

4. Deference to the customer can be morally objectionable even in narrowly commercial transactions (Sorell, 1994).

A certain view of citizenship reinforces consumerism in the health service. In a poster campaign conducted by the UK electoral commission in the 2001 local elections, the slogan 'votes are power' was illustrated by the image of a politician controlled like a puppet by the hand of a voter. This is the counterpart of the idea that patients are kings and doctors and nurses their servants: citizens are encouraged to think that when all goes well and they cast their ballots, politicians will and ought to be their playthings. Given the general contempt in which politicians are held, and the idea that, when elections come, voters should register their decisions as brawlers would, by kicking out the incumbents, the puppet image may look appropriate. And it may be harmless. After all, politicians are usually self-admiring and thick-skinned enough to bear the puppeteering imagery with no trace of humiliation. So is there any real injustice in popular attitudes of contempt even for the better politicians? Yes. It is not nothing for people to work hard at finding ways of solving genuinely difficult problems of providing health care, transport or education. It is not nothing for them to do so when much of the public would run a mile from the same tasks. If the solutions are seriously worked at, it is immoral for members of the public to be contemptuous of politicians. After all, by delegating the solution to some of the more difficult problems to those who stand for office, ordinary citizens get the freedom to absorb themselves in private life. They shouldn't – morally shouldn't – strike poses of superiority to those politicians (certainly not a small minority) who are doing their best for the rest of us. And the puppeteering image is doubly out of place. Politicians who are serious deserve to be given latitude to act for their constituents in ways they themselves arrive at. And most of the citizens who according to the electoral commission do or should pull the strings, may have no policy making interests or aptitudes at all. They may not have a clue what strings to pull and may not want in the least to find out.

Turning from politics to medicine, from citizens to patients, the idea that *doctors* should be puppets on a string goes beyond the limits of even the most strident patient consumerism. No-one is saying that patients should dictate the medical treatment they receive or pull strings attached to the hands that wield the scalpel; what patients *are* being encouraged to do is to ask pointed questions about the medical advice they receive, to get explanations, and to expect treatment within specified periods of time, with these periods to be reduced for future patients in the longer term. The effect of introducing these expectations and of taking steps to meet them is often described as that of making the health service more patient-centred. Patient centredness is contrasted with two things that are supposedly outmoded and even perverse: first, a regime in which health service practices are designed for the convenience of the staff; and second a climate of servility or undue deference to doctors. But how outmoded and perverse *are* the things that patient-centredness counteracts? The convenience of staff must surely not take precedence over medical urgency; but it must gain in weight the less life and limb are at stake, especially in a period of considerable loss of personnel from nursing and general practice medicine. It is the same with deference to doctors. Patient deference to medical arrogance is clearly out of order; but so, equally, is doctors' deference to assertive but medically ignorant patients. Doctors must be willing to explain, but they need not be prepared to go through professional life feeling embattled or threatened by adversarial or inquisitorial relationships with patients.⁵ What should drive the doctor-patient relationship is a sensitivity *on both sides* to medical need

and the desirability of health improvement; but since not everything that emanates from a patient is medical need or contributes to health improvement, *patient-centredness* gives the wrong focal point for medical care.

Some patients know a lot about their conditions, and many others are in a position to find out more about diseases they may have, or about the way they live affects their health. Those who are in a position to find out these things and can do so relatively easily ought to do so – morally ought to do so. They ought to do so with a view to taking what action they can to improve or preserve their health. The philosophical justification for this claim is that rational agents have an obligation not to disable or incapacitate themselves, and to make themselves more able to carry out their ends. It cannot make sense for people to reduce their options or their powers for no reason. Those who try to find out how to preserve their powers and to act accordingly – call them good patients – deserve things from their doctors that may not be owed to patients who are inactive or obstructive in preserving or improving their health. Good patients may deserve more consultation time and co-operation in their treatment than those who ignore good medical advice, or those who are in a position to get better-informed about their health, but who use up valuable GP time to find out things they could easily have learned in a different way. I admit that the job of becoming informed is not that of the resourceful and well-educated patient alone, but of the government, or the government in conjunction with a specialist health non-government organisation (NGO). It is for these bodies to put intelligible information within easy reach. But it is the patient's responsibility to make use of it.

Since the locus of responsibility that I have in mind is not the patient so much as the citizen-patient, responsibilities do not end with becoming better informed about health and behaving accordingly. There is also a responsibility – owed to other citizen-patients – of making responsible use of scarce resources. Take scarce GP consultation time. There are neo-liberals who think that scarcity in the NHS ought to be registered in charging, and that GP visits in particular should be paid for by all but the poorest in the UK.⁶ Whether the neo-liberals think the 'ought' in 'ought to be paid for' is the moral 'ought' is not always clear, but sometimes the thought seems to be that it is a mark of a responsible agent that he register what is important to him in his spending choices; so there is something morally wrong with any solvent adult refusing to set aside a portion of personal income for these visits.

I do not find this line of thought attractive if health care is funded out of tax or national insurance, and I think health care should be funded that way. But I agree that it is part of public morality for governments to keep track of these costs and not behave as if it were in bad taste to publicise them. Health care provided by GPs and hospitals is not a gift whose price it is impolite to advertise or ask for. It is paid for out of an insurance pool funded by the solvent and healthy for the poor and ill. It is in no-one's interests for the costs of equipment, drugs and salaries to be obscure, or for very expensive equipment, drugs and salaries to be used where they do not need to be and in ignorance of how expensive they

⁵ It is the same in education. No-one wants fawning students, who parrot one's ideas, but neither is it any help for pupils or students to test the crowd-control skills or the put-down skills of teachers. This simply takes up time and energy better spent on getting over information or ideas.

⁶ This is a long-standing neo-liberal demand. For a recent formulation, see Green (2003).

are. It is in no-one's interests for the purchasing power of public or private insurers not to exert a downward pressure on the prices of medical equipment, buildings, and drugs. Such pressure cannot be exerted if the prices of things are kept dark or are vaguely grasped by those using them. It was one of the scandals of the NHS before the Tory reorganization that the prices of a great many items were generally unknown in the NHS.

To summarise much of what I have been saying, the citizen-patient must take more responsibility, or rather that the patient must be responsible twice over, first as an autonomous agent who ought to take care of his health in co-operation with medical staff, and, at the same time, as a citizen of a welfare state in which there is a particularly widely acknowledged shared stake in the continuation of the health service. As I have said, the shared stake does not simply manifest itself in the continued willingness of people in the UK to pay more tax for a health service; it manifests itself in the unpopularity of reforms of the health service that appear to change its character fundamentally. It does not seem to me to be true that if, by waving a magic wand, the UK could suddenly introduce a wholly privatised but efficient health service, then people would endorse that change of affairs with no qualms. In the case of the health service in particular, but probably also elsewhere, there is public fidelity to a continuation of the war-time and post war-time spirit of the welfare state in which the health service was inaugurated. I am trying to point out some of the responsibilities that go with that fidelity. One responsibility, undoubtedly, is to pay for the health service. But another is a responsibility to acquire more understanding of what it takes to improve the health service fundamentally. And this understanding would have to manifest itself in *patience*, in the ability and willingness to wait.

There are two ways in which this departs from the consumerism I dislike. First, it involves citizens in taking an interest in things that go way beyond patients' charters: it means taking an interest in public policy and a responsibility to try to understand it from the perspective of those who would devise and implement the policy in good faith. Discharging the responsibilities of citizen is not only a matter of voting, but of informing oneself enough about what is possible, both politically and economically, for elected officials to deliver. It means understanding the health service from a perspective deeper than, or at any rate different from, performance tables geared to disputable performance targets. Conditions for this understanding include honesty on the part of politicians about the deep discrepancies between the two time-tables, and about the need for citizens to look beyond the length of a single electoral cycle. It would also mean a more dispassionate and longer term popular media discussion of long-term problems. Second, it would mean accepting that those using the health service now have the bad but bearable luck of having to wait longer for worse health treatment than our predecessors, while paying for reforms that will probably mainly benefit another generation. Accepting this bad luck seems the least that my otherwise extremely lucky generation can do for others, and since we're all living longer, it may be that we will survive to see some of the benefits ourselves. In the meantime, so long as there is reason to think that the right long-term plans are in place, we should bear with the politicians and others who are carrying them out. We and not just politicians should think about more than ourselves and about more than the near future.

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A comment on Sorell's paper from a political science perspective

Stephen Harrison

University of Manchester

Contemporary social theorists have remarked on the way in which consuming has displaced working as “the cognitive and moral focus of life, the integrative bond of society and the focus of systemic management... the hub around which the life-world rotates” (Bauman, 1992, p.49). This consumerism “knows no boundaries. It neither respects domains once immune from its effects, nor supports existing markers of cultural territory” (Lyon, 1999, p.76). Hardly surprising then is that governments have become infected with this culture, adopting a posture that Colin Crouch (2000, p.13) has described as “something more resembling shopkeepers than rulers, anxiously seeking to discover what their ‘customers’ want in order to stay in business”.

Moreover, whatever its historic role as an exemplar of national solidarity, the National Health Service (NHS) has not been excluded. As a political scientist whose main interests are in health policy, I recognise the political and social context of health care that Tom Sorell describes in the UK. Such consumerism fuels demands on both politicians and health care professionals, encourages the contempt (or at best apathy) with which politicians and political processes are regarded, and abets the sometimes perverse political obsession with the short term in general and with targets and performance indicators in particular.

As Sorell notes, there are features of the UK political system that fail to discourage all this. Most obviously, a flexible electoral cycle of a maximum five years gives rise to political calculations based on only three or four year periods. Assuming that this is susceptible only to minor modification (if any), Sorell suggests that the Audit Commission might become responsible for both setting NHS performance targets and for monitoring them. By this means we might both avoid the use of performance targets that (like the present obsession

with hospital waiting lists) are either meaningless or excessively crude, and help to focus performance improvements over a longer period than an electoral cycle. The NHS has been steadily and increasingly (party) politicised since the early 1980s, and the implications of Sorell's proposal is therefore a potentially radical reversal of this which many health professionals might welcome. Election manifestos and Secretaries of State would no longer set NHS performance targets. It is, moreover, a feasible strategy *if politicians of all the major parties are willing to enact it*. After all, the NHS has not always been the subject of such obsessively 'hands-on' political management, and there are other areas of public service where politicians are much readier to defer to the views of independent regulators. Unfortunately, it may take only one Party to subvert such an arrangement and repoliticise matters. Moreover, the boundary between politicians being able to set targets and set priorities is extremely uncertain. If they cannot undertake the latter, and if (following Easton, 1953) politics is "the authoritative allocation of values", then they might be held to have no function.

The main concern of Sorell's analysis, however, is less with politicians than with patients and the public. He suggests that many patients fail to act as if they were also citizens. Thus, contrary to the rhetoric of consumerism, patients may transgress in ways other than the obvious route of assaulting NHS staff. Put, as it were, the other way round, Sorell posits a number of moral responsibilities which, if accepted, might well ameliorate the problematic world that he describes. Some such responsibilities are placed on patients, others more widely. Specifically, he suggests that:

- (i) Patients should obtain and act upon information about how to recognise self-limiting conditions, so as to avoid needless use of NHS resources.
- (ii) Patients should learn to recognise and treat self-treatable conditions.
- (iii) Patients should respond positively to GPs' advice and health education publicity, presumably in relation to such matters as lifestyle and simple preventive measures.
- (iv) Patients should recognise that it might be equitable for them to have to wait for treatment for non-urgent conditions.
- (v) It might not always be unethical for health care professionals to distinguish between 'good' and 'bad' patients and to bias their efforts accordingly.
- (vi) Citizens should inform themselves of the reasonable health policy options open to government.
- (vii) Citizens should take conscientious politicians seriously, and allow them some latitude to act.
- (viii) Citizens should be prepared to meet the present day costs of NHS improvements for the next generation.

I am in general agreement with all of these suggestions and, rather than discussing Sorell's suggestions from a normative point of view, I want to consider their policy implications. If we were to accept this account of moral responsibilities, how could we put them into

practice at a policy level? Noting that neither Sorell nor I are in favour of a general scheme of charging for NHS services, his paper hints at three broad policy options: penalising 'bad' patients, providing patients with more information, and educating citizens.

Penalising 'bad' patients

Performance of some of the moral responsibilities listed above might in principle be encouraged by the development of specific sanctions. The problem though is that only clinicians are in a position to identify 'good' and 'bad' patients, yet may have no incentive to do so. Cardiac and vascular surgeons who hesitate to operate on smokers, even on the grounds of probable high graft rejection rates, are highly unpopular with the news media. The high rate of 'DNAs' ('did not attend') in many outpatient clinics often enrages health professionals (though of course some clinics simply could not function if everyone turned up). The demands of patients for antibiotics as (useless) treatment for viral infections is bemoaned by numerous GPs (but of course a prescription keeps patients happy and is a neat means of ending a consultation). I will not labour the point with further examples. And of course it hardly matches the ethical ideal of the patient relationship for the GP to impose a charge for (say) an unnecessary night call. It is much more plausible to suggest that clinicians might *informally* reward 'good' patients by perhaps being more thorough and more attentive, but this would be somewhat self-defeating in policy terms as (by definition) no example would be set to 'bad' patients (just as my lazier students never notice that the conscientious ones get far more out of me). We also have to hope that neither clinicians nor I are acting on unacceptable covert motives, such as sexism or racism. Yet professionals can solve many of our problems if only we allow them to do so.

Information for patients

A number of Sorell's moral responsibilities have information as a necessary condition. In relation to the responsibilities of patients, such matters as recognising self-limiting and self-treatable conditions and adopting the content of health education measures are examples. As he notes, it would be necessary for government to make such information more accessible; the present Labour Government has in fact made a number of moves in this direction, most obviously through the establishment of NHS Direct and other web-based health information services. But 'information' is not a neutral unproblematic concept, even (as I do) leaving out issues of epistemological divergence. First, it is not possible simply to decree that citizens should trust the authority of the Government and its experts; the recent controversy over the safety of MMR (measles/mumps/rubella) vaccine is a case in point. Despite apparently overwhelming epidemiological evidence that there is no causal relationship with autism, vaccination rates are falling, to below herd immunity in a few districts. Second, cost information does not necessarily change patient preferences in the context of third-party payment. The very high cost-utility figures for the drug Interferon Beta for relapsing-remitting multiple sclerosis (Forbes et al., 1998) have not apparently stanch patient demand. Third, there are actors other than government in the information market-place. Manufacturers and suppliers of drugs and medical devices have

an economic interest in stimulating demand for their products, even to the extent of helping to create new ‘medical’ conditions (Moynihan et al., 2002). Nor is it self-evident that the creation (as Sorell suggests) of an ‘independent’ information agency helps. Such an agency exists already in the form of the Commission for Health Improvement (CHI). Yet reports of CHI’s independent clinical governance reviews, aimed at self-improvement by NHS Trusts, have been hijacked by the Government as a component in its notorious ‘star’ rating system for those organisations.

Education for citizens

Sorell’s responsibilities for citizens imply a substantial programme of social and political education if they are to be capable of being enacted on the scale required to have any purchase on the problems described. This is an idea which has some currency, although it is only very recently that a degree in politics has been thought to be a fit and proper basis for entry to school teaching. If such a programme were to be operated in schools, care would have to be taken to ensure that it was not in practice sidelined either by a drive to maximise A-level grades or by the creation of a baccalaureate, and even then I honestly do not know whether it is reasonable to expect such learning to be carried over into adult life. That apart, I wonder how realistic it is to expect citizens to hold and update such knowledge; as an academic social scientist, I possess a good deal of this sort of knowledge but I am overwhelmed by any attempt to apply it seriously to policy topics that are very far outside my academic interests.

So what?

Although it is quite possible that these policy approaches may help, it will be evident that I have serious doubts about their efficacy. In addition to the specific points made above, such proposals labour under the disadvantage that consumerism in health care is only one small manifestation of a much larger social transformation (Harrison, 2002). It is obvious that the policy solution that most ‘goes with the grain’ of consumerism is the introduction of a general scheme of health care charges, either for the NHS or for privately-provided care. For me (and I presume for Sorell) the equity implications of such an arrangement are unacceptable, so that we must look elsewhere. If consumerism cannot be evaded, then perhaps it can be bounded by rules that limit what the consumer may expect to receive. Explicit rationing of NHS care ran into numerous difficulties when locally organised in the early 1990s (Klein et al., 1996) but there are approaches (such as Light’s ‘Cochrane test’ and Dworkin’s ‘prudent insurance principle’) that could be adapted and applied nationally to the NHS as counters to unrestrained consumerism (Light, 1991; Dworkin, 1994; see also Harrison and Hunter, 1994, pp. 67-69). But such arrangements would require that politicians court a degree of unpopularity.

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A comment on Sorell's paper from an economics perspective

Alan Williams
University of York

Sorell's principal theme is that civic morality requires politicians, professionals and the citizenry (as potential patients as well as actual patients) to accept duties and responsibilities as well as claiming rights, to manifest greater openness and honesty, and to take a more long-term view of the opportunities and difficulties faced by the health care system. But if we are to make any progress in achieving these worthwhile goals, I think we have to dig a little deeper and try to understand what motivates each of the principal players in this drama. As I see it, the problem is that each of them plays many roles, and each of these roles has different payoffs, so that each player is coping with internal tensions, as well as the inevitable conflicts of interest that arise when they are each competing for a greater share of the action.

Politicians profess a public interest ethos, so engage in high-flying rhetoric which has to be kept insufficiently specific for it not to be easy to see that they have failed to live up to their promises. Specificity is, however, needed to translate vague aspirations into managerial targets to which the professionals can respond. This in turn exposes politicians to responsibility for tough decisions, which may work against their other crucial objective, which is to obtain, exercise and retain power. They may also be using health care policy to pursue narrower objectives (e.g. sustaining the interests of particular groups on whom they depend for political support), which is rather more difficult for them to be open about, so this is another reason for keeping the level of discussion as close as possible to the rarefied strata of high-flying rhetoric, and away from specifics. Practical politics thrives on obfuscation. Public policy analysis requires clarification. They make uneasy bedfellows.

Matters are not much better when we turn to the health care professionals (among whom I count managers as well as doctors, nurses etc.). They profess a patient-centred ethos, with

its associated rhetoric emphasising their own altruism. But in their careers they desire to obtain, enjoy and retain intra-professional esteem, which comes not only from quietly doing a good job, but perhaps even more from doing exciting and innovative things which divert resources away from the practice of proven therapy into speculative high-tech activities which, if successful, will bring fame and fortune, and get them away from the drudgery of everyday practice for a while. They also face a persistent ethical problem in balancing the interests of particular patients for whom they feel a direct responsibility against those of the wider population for which the system as a whole is responsible. This ethical burden becomes especially acute when the professionals are playing a managerial role (as they all do at some stage, though often unwittingly), by deciding who shall be given priority in access to the limited capabilities of (their bit of) the system, and at whose expense (in terms of access denied or delayed). The conflict between the individual-centred ethic of the professionals in their clinical roles, and the population-centred ethic required of them in their managerial roles, is at the heart of their internal tensions.

This very same tension is also at the heart of the matter when it comes to looking at these matters from the viewpoint of the citizenry. Like the politicians, they profess an ethos of fairness, especially with respect to the NHS (and perhaps even with respect to health care more generally). They think equals should be treated equally, and those in greater need should have priority over those with lesser needs (though what constitutes 'need' in a sufficiently measurable sense to check on whether the system is delivering on this objective is usually left undetermined). But this population-centred viewpoint is likely to be severely undermined when that same individual is a patient urgently seeking treatment, when the sort of triage that needs-assessment implies becomes a threat to that individual's own priorities. At that point the clinical discipline imposed by deliberative rules about 'indications for treatment' is expected to be abandoned, and unbridled personal compassion and charity to rule the day instead. Equity and self-interest often do not point in the same direction.

Against that background, what can policy analysts do to clarify the situation and offer guidance as to which levers might be pulled in order to move the situation in the direction required by Sorell's concerns about civic morality? I think we need to start by recognising the internal conflicts of interest that each player is experiencing, and how they balance one against another in each key context. This focus on individual trade-offs at the margin is at the heart of micro-economics, but has (for understandable commercial reasons) mostly been concerned empirically with eliciting trade-offs that consumers make in markets (e.g. between price and various product attributes). But there is no reason in principle why this same approach should not be applied to eliciting the trade-offs that politicians, professionals and citizens make when trading off one objective against another (including ethical objectives). The trade-off that would be of particular interest in the present context would be that between improving the average health of the whole population as much as possible (which I will call the efficiency objective) and reducing inequalities in health (which I will call the equity objective). What would perhaps contribute more than anything else to Sorell's objectives would be to bring these into conformity with each other, so that politicians, professionals and citizens were all singing from the same hymn-sheet. But the

first task is to find out what each player's trade-offs are at present, and, if they are different, to find out why they are different and what can be done to bring them closer.

Exhortation may prove to be an effective strategy, but it needs to be rather carefully formulated and targeted, and it may well be that changing the incentive structure facing each player will prove to be more effective. That I think is the contribution that economics can make to the resolution of these problems.

FROM PAWN TO QUEEN: AN ECONOMICS PERSPECTIVE

Julian Le Grand

London School of Economics and Political Science

“Fancy what a game of chess would be if all the chessmen had passions and intellects, more or less small and cunning; if you were not only uncertain about your adversary’s men, but a little uncertain about your own; if your Knight could shuffle himself on to a new square on the sly; if your Bishop in disgust at your Castling, could wheedle your Pawns out of their places; and if your Pawns, hating you because they are Pawns, could make away from their appointed posts that you might get checkmate on a sudden. You might be the longest-headed of deductive reasoners, and yet you might be beaten by your own Pawns. You would be especially likely to be beaten, if you depended arrogantly on your mathematical imagination, and regarded your passionate pieces with contempt.”

George Eliot, *Felix Holt the Radical*

Pareto is reputed to have once said that the difference between economists and sociologists is that the former explored the behaviour of people with choices while the latter investigated the behaviour of people with none. If he did indeed say this (I have been unable to find the quote), he was broadly correct. Most economic analysis models individual behaviour as the outcome of individuals making choices, whereas traditional sociological approaches regard individual behaviour as largely determined by structural factors in the wider society, such as class position, with little role for personal decision making.¹ Sociologists thus tend to regard individuals as passive victims of circumstance: as pawns, to use the chess metaphor. Whereas economists think of the individual as the

1. I say ‘traditional sociological approaches’ to distinguish these from newer forms of sociological analyses that go under the label of rational actor approaches and are more similar to economic approaches.

central building block of their analyses: not a pawn, but the most powerful piece on the chess board, the queen. Or, to vary the metaphor, for the economist, the consumer is king.

This difference raises both positive and normative issues. On the positive side, there is the empirical question as to how much choice people really have in different situations, and how such choices as are open to them differ from individual to individual. On the normative side, there is the question as to whether people *should* have choices. Should pawns in fact be queens? This issue is of particular importance in the health care context where in many countries (and particularly in the United Kingdom) there is a tradition of the recipients of care – patients – to act as passive principals (that is, as pawns), while allowing the suppliers of health care – medical professionals such as doctors or (to a lesser extent) nurses – to act as largely autonomous agents (that is, as queens). This normative question – whether the recipients of health care should be treated as pawns and medical professionals as queens – will be the central focus of this paper.

The paper begins with some brief illustrations of the proposition concerning the importance of choice in health economics. It then addresses the central question as to where the power of choice should lie in the case of health care: with the recipient of that care or with the supplier of it? Put another way, should the patient or the doctor be pawn or queen? There is a brief conclusion.

Health economics and choice

Much (most) economic analysis involves the study of individuals making choices under constraints. Health economics is no exception. The use of health care facilities is modelled from the perspective of individuals making choices; the supply of health care is analysed using the tools of constrained optimisation. Even health states themselves have been viewed as the product of individuals making choices concerning the extent of their investment in human capital. Choice is fundamental to health economics.

This emphasis on choice is alien both to popular perception and to many of the other disciplines applied to the analysis of health and health care. The notion that people make choices with respect to their health is far from widely shared. The onset of ill-health is commonly viewed as an act of fate, not the outcome of an individual's own choices. And what economists describe as the 'demand' for health care – with the implication of agency – most people term the 'need' for health care – with the implication of constraint.

This difference is illustrated by a recent exchange in the *Lancet*. Three economists, including me, wrote a short opinion article concerning the current debate on health inequality (Oliver et al., 2002): a piece that inspired a number of critical responses. The article made a number of points about that debate, including the propagandistic presentation of statistics, and the fact that the possible opportunity cost of policies designed to reduce health inequalities was almost never taken into account by their proponents. But the point that attracted the most attention and that drew the fire of most of the article's critics was one that actually formed a relatively small part of the piece: that not all health inequalities were necessarily inequitable since some may have arisen from individual

lifestyle choices. The critics objected to the proposition both on empirical grounds – “the aetiological contribution of behaviours to health inequality is small” (Macleod, 1992) – and on methodological ones – “from my perspective, the notion of the rational citizen making informed choices about diet and other aspects of lifestyle provides an inadequate model for population health policy” (Perry, 1992).

Interestingly, the critics did not challenge the proposition that *if* health inequalities could be identified that were the result of individual choices, then they would not be inequitable. This is gratifying since I and others have argued for some time now that the issues of equity are intimately linked to issues of choice and that the extent of inequity in a given situation depends on the extent to which that situation arose from individuals’ choices (Arneson, 1989; Cohen, 1989; Le Grand, 1984; 1991). Rather, they contended that there was in fact little choice in the health context, and that economists’ modelling of health outcomes as though they were the outcomes of (constrained) choices was inadequate and inappropriate.

Now I do not wish to enter the rights and wrongs of debates over health inequalities at this point. I use the example simply to illustrate what is often a fundamental difference in approach between economics and other disciplines in their attitudes to choice. This difference also emerges in another context, however, and this I do want to address: the role of an individual’s choices in determining his or her health *care*.

Should patients be pawns or queens?

There are at least two types of argument with respect to the question as to where the power of choice over medical care should lie with respect to patients or doctors: what we might term the welfarist approach and the liberal one. The welfarist approach tries to resolve the issue by referring to the impact of its resolution on individual welfare or wellbeing: that is, whether individual patients should be pawns or queens depends on which increases their welfare the more. The liberal approach is concerned simply with the impact on the individual’s freedom: that is, whether patients should be pawns or queens will depend on which ultimately gives them more freedom of action.

To begin with the welfarist approach. In most contexts, welfarists would follow John Stuart Mill in *On Liberty* and argue that individuals are the best judges of what would contribute most to their own welfare. Hence they should have as many choices as possible, and not have those choices restricted by others. Nor should others make choices for them, for no-one can make personal choices as effectively as the individual themselves. They should be queens, not pawns.

However, welfarists often also argue that one of the contexts in which this would not be applicable is that of health care. The literature has identified a number of possible welfarist reasons why patients should not make choices for themselves with respect to medical care or indeed other aspects of their health. The first, relatively trivial, one is where people choose to be pawns. So, for instance, some patients might prefer to place themselves in the hands of the doctor because they feel incapable of making the relevant decisions even if they are offered the opportunity to do so. Although far from trivial empirically (there is evidence that this can happen quite frequently), it is trivial analytically, because these are

not really individuals ceasing to be queens. Rather they are exercising their royal powers by delegating authority to some-one else. The voluntary pawn is not really a pawn.

The more difficult arguments are those that form the welfarist case for over-riding an individual's choices, regardless of his or her wishes. The most well known of these is when he or she possesses poor or imperfect information concerning the likely outcomes of those choices. Ever since Arrow (1963) drew attention to this in one of the classic articles of health economics, the phenomenon of imperfect information and its importance in affecting the impact on individual welfare of both market and non-market systems of medical care has been the subject of an enormous amount of attention from economists, and I will not dwell on it here. Suffice it to say that the poor information argument only provides a welfarist justification for treating patients as pawns if there is no low cost way by which that information can be provided to patients. For, if the relevant information can be given relatively cheaply to patients, then, other things being equal, they are likely to be better off making their own, informed choices than if someone else makes those choices for them.

Other welfarist arguments in favour of treating patients as pawns concern what has been termed 'individual failure' (to distinguish it from market or other forms of system failure, such as poor information²). Bill New (1999) has identified four of these. The first is a technical inability to complete the necessary mental tasks. This could arise because the quantity of information is simply too great, or because the technological or causal connections are difficult to make. This appears to be a special problem with respect to health care, since this often involves assessing risk, and experimental evidence suggests that individuals often find it difficult to make rational decisions where weighing up probabilities are concerned (Tversky and Kahneman, 1982).

A second source of individual failure identified by New is weakness of the will. This is where individuals know what they prefer in the long term but still make choices that are not in their long-term interest. Obvious health-related examples are over-eating or smoking, where the relevant individuals will often assert that they would really prefer not to engage in those activities, but find it impossible to stop doing so. Compliance with drug regimes is another area where weakness of the will is often apparent.

A third source of individual failure is emotional decision making; that is, becoming attached to certain choices and allowing emotions to distort decisions. This might arise because of a strong attachment to a particular outcome even though one knows that it is very unlikely to occur; or the decision may be made in a period of stress, such as that following a bereavement.

The fourth problem raised by New concerns the relationship between preferences and experience. Preferences over a set of choices might be different if the individual had actual experience (as distinct from abstract knowledge or information) of the outcomes of the decision concerned than if he or she had no such experience. Thus, the decision whether to smoke or not might be different if it were possible for the individual concerned actually to

2. The distinction between system and individual failure has been challenged: see Calcott (2000). However, it is not crucial to my argument.

have the experience of dying from lung cancer before the decision was taken. At first sight this resembles the imperfect information concern, and as such might be thought a system failure rather than an individual one. But it is not quite the same; for in these cases no system supplies the relevant information prior to the decision being taken. No-one can experience what it is like to die before they die.

So welfarists have a number of possible justifications for treating patients as pawns. What of the liberal approach? At first sight, it might seem difficult to find any such justification from a liberal point of view; for, from that perspective, the desirability of choice arises from deontological, not consequentialist, concerns. That is, the promotion of choice is a desirable end in and of itself; whether or not the exercise of such choice has the consequence of improving welfare (or indeed any other consequence) is irrelevant.

However, even here there may be cracks in the argument. What if a particular form of medical treatment improves the choices open to an individual – as, it has to be said, most successful forms of such treatment are likely to do? Suppose it improves his or her capabilities or functionings, in Sen's terminology. Then would not the short-term restriction of patient choice be a price worth paying for the consequence of a long-term increase in the availability of choices?

Actually, the answer from a liberal point of view is, I suspect, probably not. From that perspective, an individual's freedom to choose should also include the right to choose not to enlarge his or her choice set. It would be wrong to over-ride that choice, even in the name of subsequently generating further choice. Of course, as with the welfarist case, information is important; the liberal would want the individual making the relevant choices to be fully informed about their consequences. But in general, from a liberal perspective, the patient, informed or not, should always be queen.

And medical professionals?

If we accept that individuals if left to make their own choices with respect to health care might make the 'wrong' decisions, and if we agree that this is undesirable at least from a welfarist point of view, that does not necessarily imply that medical professionals should make those decisions. To make that case requires demonstrating that doctors will do it better than the individuals will.

The case for doctors to have choices over their patients' care is in some ways the mirror image of that for not allowing patients to make their own choices. Medical professionals do possess the information about medical science and technology that their patients lack; indeed therein lies their claim to be a professional. And while they may suffer from various forms of individual failure with respect to their own decisions about themselves, they may not suffer from at least some of these when other individuals are concerned.

Consider the first element of individual failure: technical inability to make the relevant decisions. Doctors are trained to make these decisions and, moreover, are well practised at them, since they have to do them every day. Hence they are much less likely to suffer from this particular difficulty. That said, it is worth noting that there is a difference in scale: the

doctor has to make these decisions for thousands of patients, whereas the patient only has to make the decision for one: him or herself. Especially in these days of the internet, patients with serious illnesses do in fact often ‘train’ themselves in their own disease, both acquiring information and the ability to process that information. So, at least on these grounds, the case for doctor power is not open and shut.

A better argument for doctors as queens can be made with respect to the second source of individual failure: weakness of the will. Such weakness is not a problem for a doctor making decisions for others, for the temptation to ignore long-term benefits to the patient in favour of short-term ones does not apply to the doctor. There may be other, more self-interested reasons why a doctor might adopt a short-term solution to a patient’s problem (such as a desire to get a demanding patient out of the surgery at the end of the day so that the doctor can get home). But they do not derive direct benefit from the patient’s own inability to defer immediate gratification.

New’s third concern was the role of emotion in distorting decisions. In this case it seems to me that doctors are likely to be as liable to this as anyone else. Considerations of professional pride, hubris or maybe even excessive humility, could all affect medical decision making, and thereby distort decisions made on behalf of patients. This form of individual failure may be universal.

Fourth, the question of experience. Now the doctor will have a kind of experience of people making the ‘wrong’ choices. So, for instance, an oncologist will have watched some of his or her patients dying of lung cancer. However, it is still not the actual experience itself; hence this aspect of individual failure is present in the doctor him or herself, albeit to a somewhat lesser extent than in the patient.

So, overall, with the possible exception of that concerned with weakness of the will, the various components of the welfarist arguments for either individual or system failure do not seem to provide an overwhelming case for allowing medical professionals to treat patients as pawns. But there is another factor as well. The case for doctors making the relevant decisions is not only dependent on demonstrating that they could do better than the patient themselves. It is also based on another assumption, rarely mentioned in this context, but crucial nonetheless. This concerns doctors’ motivations. Specifically, for the case to stand, doctors have to be something close to perfect altruists. That is, if they are to take decisions on a patient’s behalf that are going to promote patient welfare, then they must have that patient’s welfare (and not their own) at the forefront of their concerns. For, if they do not, there is no guarantee that they will use their power appropriately. To use a metaphor that I have employed elsewhere (Le Grand, 1997), they must be knights, not self-interested knaves.

This is related to the currently fashionable debate concerning the role of trust and the public sector. The argument recently employed by, for instance, Onora O’Neill in her Reith Lectures (2002) – that we should be trusting public servants more and auditing them less – is based almost entirely upon the assumption that the public servants concerned are (perfect) knights. For if they are not – if they are knaves or even if they are imperfect knights in the sense that their decisions vis-à-vis the people they are serving are based at

least partly on self-interested concerns – then trusting them will only result in their clients' welfare being improved if their own personal welfare is also improved thereby. So to trust doctors is to assume either that their interests and those of their patients always coincide, or that any situation involving a clash of interests will always be resolved in the patient's favour.

So, unless interests coincide, for doctors to be queens they must also be knights. Is this a reasonable assumption? The literature on doctors' motivations, in the UK at least, is surprisingly sparse. But what is clear is that they are not perfect altruists. For instance, a British Medical Association survey of 600 doctors' attitudes towards medicine as a career found that over half of the respondents (58%) agreed with the statement that "medicine is a major commitment, but doctors also deserve a decent family life and leisure time"; while a further 29% felt that "the practice of medicine must be organised in a way which allows doctors to balance their career with family and other interests". Only three doctors thought that "Medicine is a vocation and only those who considered it their primary commitment should enter the profession" (BMA, 1995, part II, p.5). If this is a correct representation of doctors' motivations, then they are like the rest of us: a mixture of the knight and the knave. And in that case the dilemmas alluded to in the previous paragraph are real.

So what to do?

For me the motivational issue is paramount. The person who is most motivated to improve his or her health is the patient him or herself. Doctors may not be entirely or even largely knaves; but they can never have the same degree of concern for their patients as the patients have for themselves. Further, given that there are always going to be occasions when the self-interest of doctors will clash with that of patients, doctors cannot always be trusted to pursue patient interests above their own. Hence, from a welfarist perspective, as well as a liberal one, the patient, not the doctor, should be queen.

Of course, there are system failures, especially with respect to information; and I accept Bill New's arguments that there are also individual failures to contend with (indeed I have to accept them, since, as the supervisor of the Ph.D. where these were first developed, I have to bear a measure of responsibility for some of them). Nonetheless, these do not seem to me to over-ride the motivational point. The way to deal with the system failure lies within the systems themselves – such as setting up institutions for providing information where none exist already. Some of the individual failures are also apparent in doctors; and the remainder do not seem to me to be sufficient to negate the motivation issue even from a welfarist stand-point, and therefore to warrant the abrogation of patient choice. However, others may disagree – especially those who do not share the economist's fascination with choice.

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A comment on Le Grand's paper from an ethics perspective

Alastair Campbell
University of Bristol

Le Grand opens his stimulating paper with a quotation from George Eliot's novel, *Felix Holt, the Radical*. From this he derives the metaphor of queens and pawns that helps to convey his discussion of the centrality of choice in health economics. Eliot's novel is acerbic in its observations on individual motivations and on the movement for electoral reform, which provides the background to the novel. Her witty account of the chess game with pieces that have minds of their own is followed by the following commentary on human nature:

“Yet this imaginary chess is easy compared with the game a man has to play against his fellow-men with other fellow-men for his instruments. He thinks himself sagacious, perhaps, because he trusts no bond except that of self-interest; but the only self-interest he can safely rely on is what seems to be such to the mind he would use or govern. Can he ever be sure of knowing this?”

These further words of Eliot's capture my dilemma in commenting on Le Grand's paper. I want to criticise his conclusion that (normatively, if not descriptively) the answer to our concerns about equity in health and health care lies in emphasising individual choice; and specifically in favouring the choices or decisions of patients over those of doctors or other professionals. I am not against patient choice (who could dare to be?), but I think that Le Grand creates too stark an opposition between doctors and patients, and (more importantly) between liberalism and welfarism. I'll suggest that pawns with minds of their own could be rebellious, individualistic or autonomous, and that being autonomous is the best bet. But Eliot's words echo in my head: “Can we be sure of knowing this?”

Rebellious pawns

The chess pieces in Eliot's imaginary game are rebels. They are happy to give the game away to undercut the authority of the queen. They are literally 'not playing the game', because they don't share common aims with their ostensible leaders. Let's assume for the moment that we can overcome the problems identified by Bill New in patient choices. We would still be left with the problem of perverse or idiosyncratic choices by individuals, which undercut the effectiveness of our social systems. Refusal to wear a seat belt could be a key example here, but equally demands for immediate attention, say in a busy accident and emergency department, when one's injury is minor, would be another. In justice theory, Rawls is probably the best antidote to this kind of disruptive individualism. Although he gives lexical priority to liberty, it must always be moderated by the difference or maximin principle, which puts welfare of the worst off ahead of unfettered freedom.

Individualistic pawns

Perhaps, however, health economists have ways of dealing with the outliers who subvert the system (I leave it to Le Grand and colleagues to explain this). Let's assume instead a society of rational, self-interested individuals, who accept a degree of restraint on their wishes in order to maximise their own advantage in the long term. Following the philosophy of John Stuart Mill, they seek to avoid harm to others in the exercise of their liberty, but each has an individual life plan. I think this is what Le Grand has in mind when he advocates an information rich system in which every patient is queen, making the best choices for herself regarding health care. The problem with this is, in the words of Gilbert (in the *Mikado*), "when everyone's a somebody then no-one's anybody!". Or, to go back to the chess metaphor, there is no game if every piece is a queen. I cannot imagine why, in this scenario, there would be any majority support for dealing with inequalities in health care provision, provided only a minority was ill served. In the *Lancet* paper, referred to by Le Grand, this possibility is discussed, in terms of needing to make a case for an equity-efficiency trade-off (Oliver et al., 2002).

Autonomous pawns

This leads me to a third possibility, which seeks to evade the sharp contrast made by Le Grand between liberalism and welfarism, and which sees patients and health professionals in a partnership for better health, rather than in a competition for power and control. In this scenario every chess piece is playing the same game, though each has different roles. This is best captured by the term 'autonomy', which must be distinguished from independence or individualistic choice. In his paper, Le Grand referred to Onora O'Neill's Reith Lectures, suggesting that she placed too much faith in the 'knighthood' of professionals. I think he misunderstood her basic stance, which is quite compressed and simplified in these lectures, but much more clearly articulated in her Gifford Lectures, now published under the title, *Autonomy and Trust in Bioethics* (O'Neill, 2002). O'Neill has for some years been reviving an interest in Kant's account of autonomy and seeking to apply it to current social issues, including health care. Her interpretation of this central concept in Kant's moral philosophy is worth quoting at length:

“[Kant] does not see autonomy as something that some individuals have to a greater or lesser degree, and he does not equate it with any distinctive form of personal independence or self-expression, let alone with acting on some rather than other sorts of preferences. Kantian autonomy is manifested in a life in which duties are met, in which there is respect for others and their rights, rather than in a life liberated from all bonds.”
(O’Neill, 2002, p.83).

If we apply this to the NHS we may see the provision of health care as a mutual enterprise, which grants rights and imposes duties on patients and professionals alike. Both professionals and patients can be knaves as well as knights – this philosophy does not deny that we all fail at times in our duty. Nevertheless, there are duties, of universal application, which must as much prevent patients as professionals from abusing the service out of narrow self-interest. This does not make patients passive, mere recipients of care whose own choices are ignored, but it does describe commitment to a shared ideal (solidarity if you like (see Ashcroft et al., 2000)), which requires the pursuit of equity in health care provision.

So I suggest autonomous pawns (and queens), not the economist’s individual chooser, detached from societal commitments, to establish a more equitable health care system. But of course Eliot’s words echo in my ears, “Can we be sure of knowing this?”. No we can’t, but it is worth aiming for.

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A comment on Le Grand's paper from a political science perspective

Rudolf Klein

London School of Economics and Political Science

From the perspective of a non-economist, the great and enviable strength of the discipline is the ability of its practitioners to devise simple models and, by so doing, to derive elegant propositions that appear to bring order to a messy, complex world. Julian Le Grand's paper is a good and illuminating example of this analytic strategy. But illumination comes at a price. For complexity comes back to haunt us. Pawns or Queens? Knights or Knaves? It all depends on context and circumstances, I will argue. Like Le Grand, I reject the kind of all-embracing social determinism that denies any role to individual choices in determining lifestyles or other forms of behaviour that affect health, as distinct from exploring why (and in what respects) there are variations in individual choice sets and decisions. Like Le Grand, too, I would also subscribe to the view that choice is intrinsically desirable, though I would put rather more emphasis on choice as a necessary condition for personal autonomy. Economists have no monopoly in holding such views, although they are perhaps unique in making them a touchstone of disciplinary faith while heterodoxy is the norm in other areas of scholarship.

But the logic of Le Grand's argument can, surely, be carried one step further. To the extent that there is free will then indeed (like Eliot's chessmen) we can choose when and whether to be pawns or queens, knights or knaves. In turn, our choice of roles will no doubt vary over time and reflect the context in which such decisions are taken. In other words, we are not necessarily dealing with discrete, antithetical categories but rather with a repertory of roles for quick-change artists. To the extent that free will is constrained by circumstances, however, we can ask how those circumstances can be changed in order to extend individual choice sets and to promote the adoption of those roles which we judge to be socially desirable

and appropriate for specific contexts. In what follows, I shall therefore explore the implications of complicating Le Grand's analysis by taking account of context contingency and institutional factors. In doing so I will pay particular attention (in line with my own remit for bringing a political science perspective to the discussion) to the opportunities for public policy to shape the context and institutions in which decisions are taken.

First, to clear some ground briefly, let me turn to health-related behaviour. This, it seems to me, raises a rather different set of issues from that prompted by the main theme of Le Grand's paper – the respective roles of doctors and patients. But it does illustrate my contention that the choices made are not independent of context and that public policy plays a part in shaping that context. On the one hand, public policy may widen the available menu of choice, for example by providing or subsidising swimming pools or running tracks in areas which do not provide a natural habitat for health clubs. On the other hand, public policy may constrain the menu of choices in order to discourage what are regarded as undesirable activities. In both cases, state intervention may be justified on the grounds of the externalities yielded. In the first instance, encouraging active exercise may – if it produces healthier people – lower the burden on the NHS. In the second instance, discouraging or limiting the scope for smoking may reduce the damage done to others – with the added (if perhaps dubious) justification that smokers cannot, as addicts, be regarded as being able to make a free choice (Goodin, 1989).

Now for Le Grand's central question as to “where the power of choice should lie in the case of health care: with the recipient or with the supplier of it?”. The difficulty here is that the question invites a general either/or response when, as we all know, encounters between patients and doctors take place in a range of very different situations. At one extreme is the sudden shock, such as a heart attack or a ruptured appendix. Here inevitably the patient is a pawn: he or she is unlikely to lecture the medical staff on the appropriate form of treatment. At the other extreme is the patient who requires routine elective surgery, say a new hip or knee. Here the patient may indeed be queen (if we must use this terminology): he or she knows exactly what they are shopping for and has the time to search out in advance information about the performance of different providers. In between there is the patient with a chronic condition. Here, while the patient may start off with an information deficit compared to the professionals, they are likely to acquire over time (as Le Grand argues) their own kind of expertise: the pawn may thus, in time, become queen. Indeed transitions and transformations may be the norm within the same episode of illness: I may be entirely dependent on the doctor to make an accurate diagnosis but as soon as I have recovered from my heart attack or appendectomy, I may well want to reclaim my sovereignty when it comes to determining my convalescent regime. Nor can it be assumed that doctors will invariably act as queens unless checked by rebellious pawns. In many situations they may see their role as laying out the choices – for example, as between operating now or pursuing a policy of watchful waiting – while leaving it to the patient to make the decision, in the light of his or her own trade-off between different kinds of risk, valuation of extended life and tolerance of pain. Le Grand's antinomian model leaves no scope for co-operation and negotiation.

One possible response to this point might be that co-operation and negotiation, if they are not to be a sham, depend on something approaching equality in power between the actors:

everyone a queen (or possibly everyone a pawn). In short, it can be argued that the presumption should be that patients are queens even if we know that in practice there will be many situations in which they cannot exercise sovereignty. And here we come to a crucial sentence in Le Grand's paper: "The voluntary pawn is not really a pawn". If a patient delegates decision making authority to the doctor, Le Grand argues, he or she is not ceasing to be a queen. The very fact that it is up to them to decide whether or not to delegate authority shows that they retain sovereignty. But why should they delegate authority? One reason, Le Grand suggests, is "because they feel incapable of making relevant decisions". And the Bill New catalogue suggests a variety of other possible reasons: the difficulty of dealing with probabilistic assessments of risk, emotional distress and so on. But surely the main reason is that medical interventions are 'credence goods', where the consumer "needs to rely on the experience of others (reputation) or trust in the seller (professional norms)" (Sloan, 2001). Publication of league tables of surgical performance and suchlike does little to change that, given the problems of interpreting them: the evidence from the United States is that these are important in changing the behaviour of providers rather than consumers. Moreover, exercising choice is not costless, in terms of time and stress.

So we come to the centrality of trust (Mechanic, 1998), dismissed all too easily by Le Grand. Here I would challenge his contention that doctors have to be "something close to perfect altruists" if their decisions are going to promote patient welfare. Let us concede that they are neither knights nor knaves but fallible human beings, concerned about having a decent family life and leisure time and able to balance their career with family and other interests. But does that mean that they cannot be trusted? Here we come to the role of public policy: the design of institutional sanctions and incentives to encourage them to act like knights even though they may have a knavish streak beneath the skin. On the one hand, we have State-sponsored institutions of professional self-regulation like the General Medical Council whose "principles of good practice" (General Medical Council, 2000) read like a code of knightly conduct. On the other hand, we have State-created instruments of inspection like the Commission for Health Improvement. Moreover, public policy can – in theory at least – change perverse incentives, such as private practice, which can encourage doctors to indulge in knavish behaviour or introduce positive incentives to reward knightly behaviour. Trust may be misplaced: Dr. Shipman's patients, by all accounts, had a great deal of trust in him. And the efforts to devise instruments for controlling knavish behaviour may back-fire, inasmuch as they undermine trust by revelations of inadequacy, incompetence or worse. However, it seems clear that regulation can ensure that most if not all doctors will promote patient welfare most of the time even if they are less than "perfect altruists".

There is, however, a further complication. Patients, when they delegate authority, see doctors as their agents who will work the system to their advantage (and are better able to do so than the patients themselves given their insider position and knowledge). But there is a tension here. Doctors also allocate scarce resources. In health care systems like the NHS and managed care organisations, they ration. Given that they work within constrained budgets, they may offer less than optimal treatment to individual patients. Indeed they may – and often do – see themselves as pawns in this respect, with managers as queens. However, this tension cannot be resolved by proclaiming the patient sovereign. For this, surely, implies that patients should have the right to determine the level of resources to be

devoted to them – the transformation of need-led systems like the NHS into demand led systems. The conclusion must therefore be that maximising individual patient choice is incompatible, given constrained budgets, with maximising the welfare of the patient population as a whole unless there were an open-ended financial commitment to health care. Short of that, patient sovereignty is likely to be an illusion.

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DEMOCRATIC VALUES, PUBLIC CONSULTATION AND HEALTH PRIORITIES: A POLITICAL SCIENCE PERSPECTIVE

Albert Weale ¹
University of Essex

Like the darling buds of May, democratic values appear to be breaking out in the NHS. Despite the abolition of Community Health Councils, we see the evolution of public consultation and involving members of the public in decision making. NICE has established its Citizens Council to consult on rationing decisions (NICE, 2002). The Local Government Act 2000 requires local authorities to establish overview and scrutiny committees with a remit to secure improvements in local service provision (Bradshaw and Walshe, 2002, p.28). The NHS plan is committed to putting a patient representative on every trust board. The Patient Advice and Liaison Service has been established. Many trusts and authorities in recent years have been experimenting with various forms of patient and public involvement, and there have been a number of experiments, prompted by Institute of Public Policy Research and the King's Fund, with new forms of citizen involvement in decision making. Representation in deliberative forums, if not participation, is the latest game in town.

Apart from the examples I have just cited, there are many more examples of a trend towards increased public consultation in health care, especially if we construe health issues widely

1. Various versions of this paper have been given at King's College London and De Montfort University as well as the HEN seminar on November 11th 2002. I should like to thank participants on all occasions for their comments. I am especially grateful to Raanan Gillon and Hugh Gravelle for acting as discussants at the HEN seminar.

to include public and environmental health as well as ethical issues arising from human genetics and reproduction. Thus, both the Human Genetics Commission and the Human Fertilisation and Embryology Authority have enhanced their consultative practices in recent years. In separate reports the Royal Commission on Environmental Pollution (1998) and the House of Lords Science and Technology Committee (2000) have advocated the increased use of devices for public consultation. And on certain matters, like the disposal of low and intermediate level nuclear waste, the practice has even gone so far as to require consultation about how best to consult. Whether even higher levels of reflection will occur is a matter for some speculation.

There are a number of reasons that can be offered for this flourishing of interest in public consultation, including a recognition of the complex interplay of the value and technical components of many health-related public policy issues as well as a desire on the part of policy makers to guard against the criticism that their decision making style is elitist. However, in this paper I want to look not at the causes but at the rationale of public consultation. In particular, I want to pose the question of what we can and ought to expect from the growth of consultative practices. I consider the growth of these forms of public consultation in the light of the traditional conception of democratic accountability in the Westminster system. I also seek to identify the various purposes or values that public consultation can serve, in order that we can be clearer in our minds about what can and what cannot reasonably be expected of an appeal to public values.

Before looking at questions of accountability and values, however, it will be useful to have a checklist of types and forms of consultation, which I provide in Table 1. This is intended to be illustrative rather than definitive.

Some of the techniques, like inviting written responses to consultation documents, have been practised within the Westminster system for a number of years, so that they can be seen as part of that system. Others, like citizens' juries and deliberative polls, are recently developed techniques, where the relationship to established forms of decision making needs to be thought out more clearly. Still others, most notably the referendum, are theoretical possibilities, which if implemented would change in a fundamental way the basis of the system. To appreciate how these various possibilities relate to the established pattern of health care governance, it is useful to look at the operational principles of the Westminster system.

The traditional Westminster model

The central principle of the Westminster system of government is that of accountability. On this view, democratic government is accountable government. The main mechanism for accountability is that of elections. Teams of politicians, gathered in political parties, stand for office, and the party which can secure an overall majority in the House of Commons is entitled to form the government. That government faces an opposition whose duty it is to oppose. In the political contest that ensues, the electorate make up their minds on the merits of the government's performance, and if they judge that the performance is unsatisfactory or that the opposition would do better, then they can vote the current rascals out at a general election and put new rascals in their place. Note the word 'accountability'.

Table 1: Types and forms of public consultation

Type of consultation	Form of consultation
Public meetings, including exhibitions and open days	The traditional methods of public consultation, particularly where the issue is the reconfiguration of services.
Invitations to written responses	A traditional method of consultation, which usually accompanies other forms of consultation.
Focus groups	These are now well known in market and public opinion poll research. They involve bringing together about a dozen people to discuss a particular issue, and the point is to explore views in depth in a way that is impossible in a traditional one-to-one interview through standard opinion polling techniques. They should not be seen as a consultative technique strictly speaking, because they are not convened in the context of a decision process that is made clear to the participants. Rather focus groups are used to explore the deliberative dimension of an issue, often in the context of a mass poll or as preparation for one of the other methods identified below.
Citizens' jury	These resemble focus groups in that it is a small group of people (usually 12 to 16) intended to be a cross-section of a target group, often in a situation in which a commissioning body is particularly interested in receiving contributions to the making of a specific decision. The jury hears evidence from experts, witnesses and other interested parties about the policy choice and, on the basis of the evidence and the presentations it has heard, the jury is expected to make a recommendation that is unanimous, consensual or showing only small points of difference. Juries run by the Institute for Public Policy Research, for example, have been asked to consider the principles by which health care resources should be rationed, how services for those with severe and enduring mental illness can be improved, what are the priorities on services for palliative care for the dying and how best finance for the NHS should be provided. Juries financed by the King's Fund have been asked to consider the location of specialist cancer services, primary care alternatives for GPs and the purchase of services for back pain.
Consensus conference	About a dozen lay people are appointed to a panel, and they conduct an investigation on a particular issue, examining witnesses at a public conference lasting a number of days. Following the conference the panel writes a report which is presented to the public. Such consensus techniques have been used in the UK in connection with novel biotechnology.
Community forums/panels	A variant of the small group technique is to maintain a continuing panel of citizens, with a rolling membership, and ask for their opinions on policy developments as they occur. It is an approach used by Somerset health authority among others.
Rapid appraisal	A technique in which decision makers consult key members of the community to gain a view about the state of opinion on an issue.
Deliberative poll	A statistically representative sample of people is brought together in one place for a few days having had their opinions polled on an issue. They hear evidence from witnesses and participate in group discussions. After the deliberation, views are polled again to estimate the direction and size of change.
Referendums	An issue of put to the vote by the electorate at large. The referendum question may be framed by a decision maker or through citizens' initiative.

In the Westminster model, it means exactly what it says: those in authority have to render an account, explain themselves if you will, to the people at large.

If you think of British government in this way (and I am not advocating this model, I am simply trying to report on what I see as its implicit principles), then certain features of British political practice which might otherwise seem obscure suddenly come to have a rationale. Take for instance the electoral system. The first-past-the-post electoral system magnifies the share of the vote of the winning party in the election in terms of seats in the House of Commons. Thus, a government like the present one elected on about 44% of the popular vote nonetheless has some 60% of the seats in the House of Commons. Indeed, no party since 1935 has succeeded in winning a majority of the popular vote, even though there have been a number of occasions when governing parties have had large majorities in the House of Commons. If we took the functions of elections to be the representation of the spread of opinions in the country at large, it would be perverse to magnify the vote share in this way. But from the point of view of a doctrine of government based on the idea of accountability, it makes perfect sense. If you simply reflected the distribution of votes in terms of seat share, you would have a coalition government, and coalition governments muddy the waters of accountability. Parties in the governing coalition would always point to their coalition partners as the source of unpopular policies.

So the fundamental idea of the Westminster system of government is accountability. Accountable for what? In historical terms, the main answer is the raising and spending of public money. The government is accountable for the money that it raises, the items that it spends it on and the standards of public service that result. The mechanism of accountability for all this activity is institutionalised opposition in parliament. And every so often the electorate is presented with the opportunity of choice between the governing party and the opposition.

When the National Health Service was established in the 1946 legislation, it was this doctrine of democratic control that was incorporated into its governing structure. Once the decision had been taken to organise the health service along national lines, then it almost automatically followed that the Westminster model of democracy would prevail. Of course, the decision to make the service a national one was not itself automatic. Bevan first had to defeat Morrison, the staunch defender of local government, in the Cabinet, and he did so in part by appealing to the argument that it was unsound to leave local government with a service that was largely financed by the Exchequer. He also had to conciliate the local authority associations by promising them representation on the Regional Hospital Boards.

Despite the opposition, Bevan got his way. The logic of the position that responsibility for the service should follow the money was difficult to assail. Moreover, we should remember the circumstances in which all this was taking place. This was at a time when politicians could say, and rightly say, that democracy had defeated totalitarianism in Europe. The Westminster system enjoyed as much intellectual and political prestige as it ever had in its history. When Bevan said, in a much quoted remark, “when a bed-pan is dropped on a hospital floor, its noise should resound in the Palace of Westminster” (Nairne, 1984, p.34), he was capturing the prestige of the Westminster system for his creation.

Bevan's bed-pan doctrine was correct as a prediction. From the centralisation of decision making the centralisation of discussion about local issues and circumstances followed. Bed-pan issues have been a feature of parliamentary debate and questions about the health service since the NHS's inception. Some recent examples will serve to illustrate the point. In 1995, for example, the Prime Minister of the day, John Major, found himself explaining at the dispatch box why an emergency patient had been moved from London to Leeds, and his health secretary had to explain why part of an Edgware hospital accident department should close (Jenkins, 1996, p.265). Rudolf Klein and Bill New list a series of parliamentary questions on 22 July 1997. These questions concern the accident and emergency facilities at Solihull Hospital, waiting lists in Stretford and Urmston, and the funding of nursing and residential home places by Wiltshire Social Services. Thus, local matters necessarily become national under our existing system of health governance.

Since Bevan's time there have been many changes made to the governance of the NHS, but none of them (with the exception of Scottish devolution) has departed from the fundamental principle that in a national service democratic control should be exercised through the UK parliament. Central government provides the bulk of the money, and it is held collectively responsible for the running of the service. When the last vestiges of local authority representation were removed in 1991, this was only confirming what everybody knew to be the case. Health authorities had to account for themselves to the government, not to the populations their services covered.

I suggest that a number of features are associated with this formal doctrine of accountability, as follows:

- (i) Since the vast bulk of health care expenditure is raised through general taxation, the opportunity cost of decisions on the volume of spending are institutionalised in the system of public expenditure control through the processes of bargaining with departments. Allocating resources to health care is always done therefore under the shadow of other priorities.
- (ii) Since public expenditure is so important, the politics of post-code rationing is programmed into the system. In a system that prides itself on being national, it is difficult to defend local variations in service provision that are not related to variations in need or to variations in the ability of decision makers to measure and assess need.
- (iii) The dominance of national politics in health care decisions means that party electoral competition is important. Yet in making a judgement on the performance of the government of the day, electors have potentially to focus on many things, of which the performance with respect to health policy is but one. Indeed, when political scientists have sought to model popularity functions for incumbent governments, economic variables have turned out to be powerful predictors. How well the government has managed the health service has fallen into the background for most of the post-war period, except 1987-88 and in recent years after new Labour raised and then disappointed expectations about the improvements they could deliver in the NHS.

- (iv) The Westminster system also encourages executive dominance of the legislature, so that there is little incentive for parliamentary involvement in deliberation on health service needs and priorities. The executive dominance, however, is also accompanied by the need to devolve routine decisions and implementation to health authorities, trusts and professionals, meaning that much of the experience of patients is shaped by processes of decision that do not take place in Westminster. Managerial and technical rationality often in practice supplant other forms of decision making.

The rationale of public consultation

It is possible to provide several rationales for increasing the amount and quality of public consultation in the making of health policy. These rationales are as follows.

Identifying competing perspectives, particularly in respect to their moral dimensions

Public participation may help to identify the relevant competing moral considerations to policy makers. For example, in the public consultation by the Wellcome Trust (2000) on cloning, it turns out that there is a consensus across many different groups that therapeutic cloning is regarded as morally acceptable, but not reproductive cloning. This function of identifying a range of considerations seems to be behind NICE's decision to establish its Citizens Council. Sir Michael Rawlins is reported as saying that the Council "is designed to provide a backdrop against which we and the independent groups that advise us can make their recommendations" (Kelly, 2002).

In its invitation to citizens to join the Council, NICE provides an interesting example of where an ethical dimension might be important. It cites its advice that products that might stop people smoking should only be available on the NHS to people who have demonstrated a real willingness to give up. There is clearly a delicate balance here between incentive and desert considerations, as well as an issue about how need is to be balanced off against effort. These balances cannot be struck in a purely technical way, and it is easy to see how extending the range of consultation to lay-people could help gain a better understanding of this process. One reason why this might be important stems from the principle of the unrepresentativeness of representatives, particularly those who serve on government advisory bodies. Appointments to such bodies are largely on the grounds of expertise and therefore the people appointed are unlikely to reflect the full range of opinions in society at large. NICE has provided statistics showing how the membership of the Council matches crucial demographic features of society at large.

There is a potential problem with this approach, however. It could be said that the traditional doctrine of accountability was being called into question by the appointment of the Council. This criticism has been made by Evan Harris in his comment on the Citizens Council: "NICE are simply trying to take shelter behind an unaccountable group of unelected public frontmen." (Kelly, 2002). Here we see well illustrated the potential conflict between representativeness and accountability as values. The difficulty with the Harris position, however, is that it seems to confuse the functions of consultation with decision making. NICE may embrace a wider range of considerations in its decision making through

the establishment of the Citizens Council, but its decisions will still be its decisions. So here we have a crucial distinction between the principles of consultation (the right to be heard) on the one hand, and the principles of decision making (the right to have an effect) on the other.

Rectifying an imbalance of political and decision making influence

Mechanisms to encourage public participation can be justified in order to rectify an imbalance of political influence, particularly when there is a worry that concentrated producer interests may dominate the process. Such domination is implied by Olson's (1965) logic of collective action, in which concentrated interests, like producer groups, have a greater incentive to act collectively and lobby in the political process than dispersed groups, for example citizens affected by a hazard. One way of thinking about this is to see public consultation as a way of enhancing the value of democratic responsiveness. In a democracy, the government should be responsive to society at large rather than any particular section of it, no matter how important.

It is concerns about the imbalance of influence that has driven the desire to build up public consultation as a way of monitoring standards and performance. I pointed out earlier that one of the consequences of the NHS system of governance was that central decision makers had to rely on local and professional actors to deliver the service. Where there are concerns about professional domination, it becomes appealing for policy makers to stress voice as a form of countervailing power. In the UK there has been a certain irony in the pursuit of this goal. Politicians and to some extent managers have seen increased public consultation as a way of dealing with the abuses of professional discretion, at the same time as health care professionals have held a higher place in public esteem than either managers or politicians.

Improving the technical quality of decisions

Sometimes public participation is advocated on the grounds that it improves the technical quality of decisions because those who become involved can identify problems that were not apparent to a smaller group of 'experts'. This argument has been advanced in the case of environmentally-based health hazards. A careful exponent of this view is Brian Wynne (1996), basing his position on an analysis of the official response in the UK to local concerns in Cumbria about nuclear contamination, especially the contamination of sheep grazing areas by the fall-out from Chernobyl. His empirical point is simple, but significant: official informed discourse misunderstood the nature of the problem it was dealing with and compounded its error by marginalising the voices of local farmers who were right because they understood at first hand the soils with which they are familiar.

It is difficult to come up with as clear a cut case as this in the case of resource allocation, but one such example might be the identification of side-effects from drugs. Advocates for schizophrenics have argued that in decisions on drug regimes, the seriousness of the side-effects of traditional drugs has been downplayed as part of the argument for resisting more expensive new pharmaceuticals. Conversely, I suppose it could be argued that patient groups who have drawn attention to the benefits of marijuana for multiple sclerosis sufferers are making a contribution to the technical debate.

The publicity condition in a democracy

A more direct argument of democratic principle is suggested by discursive or deliberative theories of democracy (for a collection, see Bohman and Rehg, 1997). According to these views, democratic decisions should be capable of meeting a publicity condition according to which the reasons for any decision should be capable of being set out in public. Clearly, some forms of public consultation will provide a test for whether this condition is met. In other words, the ability of decision makers to explain to a consultative forum the rationale of their decision provides some test that a publicity condition has been met.

One irony here is that the most obvious form of consultation that meets the publicity condition is the form that typically receives most criticism, namely the public meeting. Other forms of consultation involve some selection of participants, whereas in principle the public meeting is open to all who are affected by or take an interest in a decision. A similar point could be made about invitations to written submissions. The opportunities presented by public meetings and invitations to written submissions are of course only taken up by a small proportion of the population. Perhaps one should simply say that the model of the New England town meeting is not a good one for public consultation in a representative democracy.

Understanding the public's structure of beliefs

It is a mistake to think that the sole way in which public consultation might work is directly through providing information on particular decisions. Sometimes its value might reside in providing decision makers with information on the beliefs of the public that form the general background to particular decisions.

One interesting aspect in this context is the issue of the extent to which the public holds consistent beliefs, a topic that has recently been reviewed by Kneeshaw (2002, chapter 4). Kneeshaw draws attention to surveys in which the public appear to give inconsistent responses to seemingly identical or similar questions. For example, in a 1991 Gallup poll, 77 per cent of respondents agreed with the statement "Everyone should have all the health care they need no matter how much it costs", whereas in a 1994 Gallup poll a virtually identical proportion, 79 per cent, agreed with the statement "The NHS will always have to work out priorities so that some types of treatment and patients are given higher priority than others". It is of course possible that there was a substantial change of mind in the three year period, but it seems more likely that what is being picked up here are subtle but important question-wording effects. There are similar, if not so striking, inconsistencies in other survey findings.

Kneeshaw points out that we should be careful not to interpret question wording effects as indicating lack of attention on the part of respondents. In particular, people may respond one way to a question about what people think the ideal should be ("Everyone should have all the health care they need...") and what they think economic realities will force upon society ("The NHS will always have to work out priorities..."). However, even if we do not take such a charitable line, there is something of importance in the fact that there are conflicts of belief in the resource rationing area, since it indicates that there are genuine

ethical and political dilemmas. Understanding what the public thinks about issues of health-care allocation raises important dilemmas, and means that the frame of reference within which policy makers approach such questions should recognise the problematic nature of any decision that is finally made.

Legitimacy

Some decisions seem so fundamental and seem to involve such existential questions for society, that decision making by direct public participation seems the only way of settling the issue. Examples might include the Swedish referendum on nuclear power and the Swiss referendum in 1998 on biotechnology. In the health rationing area it is difficult to think of comparable referendums that have taken place. The referendum on Scottish devolution could be cited as an indirect referendum on resource allocation, since the decision to devolve priority setting to the Scottish Parliament has certainly had resource allocation effects, most notably in the funding of long-term care. However, in terms of specific health care decisions, the referendum is not used.

At one time it was sometimes suggested that deliberative polls could almost substitute for actual referendums. The logic of this argument was simple. Voters' decision making in referendums suffered from the problem of 'rational ignorance', the fact that it was not worth an individual's time and trouble to find out about the issues because his or her influence on the overall result was infinitesimally small. In a deliberative poll the participants are provided with information, and with sufficiently good sampling we could infer from a deliberative poll what the electorate would think if they were well-informed. However, this is clearly to confuse the role of providing information on preferences and attitudes with the responsibility for the making of decisions. No matter how sophisticated our consultative procedures are, they are no substitute for the exercise of responsibility by those authorised to make a decision – though of course the authorisation could extend to the population at large in an actual referendum.

Providing information on the social welfare function of a society

In some older welfare economics literature it was possible to find the claim that the political process itself could be seen as a social welfare function (Nath, 1968, p.128), but this was always a rather implausible proposition. A social welfare function is a mapping of a statement of individual preferences over alternative social states into a statement of collective preference. Merely having the political process make a decision cannot be regarded as a mapping of preferences at all. But it is possible to imagine that public consultation could serve as such a statement of preferences. QALY estimates, for example, require some understanding of the relative value that individuals place on various combinations of disease/disability states. One can think of public consultation as a way of providing this sort of information.

However, I suggest that we need to think carefully before simply substituting public consultation for the assessment of a social welfare function. If a social welfare function is a statement of *individual* preferences, then we ought to be looking at the form these take

before citizens enter into deliberation with one another. Indeed, in some ways the idea of a social welfare function offers a mechanical rather than deliberative solution to the problem of social choice. From this point of view, if we are going to obtain reliable information on the relative values that individual citizens place on competing health states, then well-designed survey or experimental evidence is more suitable than the sort of evidence that is gained in public consultation exercises. Indeed, to the extent to which public consultation takes a deliberative form, it would seem that these consultation exercises might usefully be fed information from survey and experimental evidence on what individual preferences are.

Avoiding unnecessary confrontation and creating the conditions for consensus

Consider the cases of 'hard choices', for example the closing of a local hospital or the denial of expensive drug therapies to a minority group of patients. One hope for new forms of public consultation is that they will be mechanisms for generating a social consensus on these hard choices so that difficult decisions become easier to implement. This has certainly been the hope in some quarters.

There is quite a bit of political theory, influenced by the work of Habermas (for example, Habermas, 1996) in which consensus is seen as the ideal outcome of deliberative processes. However, it seems to me that there is one obvious problem with this approach. Unless we are terribly Panglossian about social dialogue, there is no reason in general to think that public consultation will always issue in a consensus on hard choices. It may simply provide the grounds on which some people come to think that they have the better of the argument, though they are a minority voice. Moreover, the greater one strives for consensus, the less one has the capacity for the sort of Popperian critical rationality that may be important in making for progress. To be sure, there may be greater acceptance of a decision if there is a sense that it has emerged from a fair process in which all voices have been heard. But there can be no guarantee.

Conclusion

The traditional Westminster model of accountable decision making has come under a great deal of attack in recent years. The prestige of the immediate post-war system has fallen away. The demands for public consultation reflect a desire to enhance democratic values in the making of health care decisions. However, existing forms of public consultation may provide information through enhanced representation but can never substitute for authoritative decision making processes. The task, therefore, is to design public consultation so that it reinforces, rather than undermines, the tasks that decision makers face. For that we need a political theory of public consultation.

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A comment on Weale's paper from an ethics perspective

Raanan Gillon
Imperial College

Weale points to the budding of 'democratic values' in the NHS as demonstrated by developments such as focus groups, citizens juries, community forums and the NICE Citizens Council. He asks (a) what their relationship ought to be to the established Westminster parliamentary value of accountability, and (b) what purposes can be achieved or values substantiated by such public consultation. In response to (a), he argues that while for historical reasons a centralised control of the NHS has resulted from the strong emphasis on accountability of the Westminster model, this results in a relative lack of representation of the population's views on health issues. In response to (b), he offers as plausible candidates identification of competing perspectives (especially moral perspectives) on health issues; broadening the range of political influences on the parliamentary processes; improving the quality of parliamentary decision making (especially its technical quality); facilitating the public explication of parliamentary decisions; and adding (or even providing) legitimacy to parliamentary decision making. He also mentions but rejects the possibilities that such public consultations might be ways of establishing public preferences and of helping to achieve public consensus and avoid unnecessary confrontation.

What sort of answers come to this medical ethicist's mind? Those who know him will also know that he finds four *prima facie* ethical principles, values, or commitments of central and widely acceptable importance in health care ethics and indeed in ethics generally. These are, of course, the Beauchamp and Childress 'four principles' of respect for autonomy, beneficence and non-maleficence, and justice (Beauchamp and Childress, 1979; Gillon, 1985). These, along with considerations of how to prioritise or choose between them when they conflict, and along with considerations of their scope of application (to whom or even

to what are these moral obligations owed?), afford a helpful basis for analysis in health care ethics, compatible with a very wide range of moral perspectives. Can they be helpful for analysing the questions that Weale asks? In this brief response I shall touch on only a few issues in the light of this framework.

The Westminster model (the 'accountability model') and its effect on the NHS

Weale distinguishes between the Westminster accountability model and, for example, proportional representation and other coalition models, which he suggests might be called Representative models, though I'll call them consultative models because both sorts of democratic model see themselves as representative. An important difference between them can be seen as analogous to the difference between, on the one hand, the exercise of autonomy manifested by a car owner who hands over his car to a garage of his choice, obtaining an estimate of the likely cost, and leaving the mechanic to get on with repairing his car (and deciding after the event whether or not to use that mechanic again) – the 'rationally ignorant' exercise of autonomy; and, on the other hand, that manifested by a car owner who wishes to be closely involved in the processes of repair, helping the mechanic to decide not only what to repair but also how to do it. The Westminster model is perhaps closer to the former, while the structure (and to some extent the practice) of consultative models of proportional representation governance is aimed at giving more power to the electorate to inform and influence the decision makers (parliament and government). As Weale suggests, the main problem with the consultative model of democracy is lack of accountability (for which of the coalition parties was responsible for the actions taken?), and one might also add the frequent, though not inevitable, inefficiency of such models (inability to agree on what action to take, frequent collapse of coalitions, frequent elections, not much action); and also the sometimes perversely *unrepresentative* outcomes that stem from coalition horse trading. On the other hand the advantage of consultative or proportional representation models is that they tend to build into the structure of their typically coalition governments the need for consultation between the different perspectives represented in those coalition governments – hence my choice of the term 'consultative model'.

But given that we have the Westminster model, and given also that it has currently spawned a government with a large parliamentary majority, why should such a government bother with developing methods of consultation in the NHS? Well let's try the four principles analytic approach to answer this question. Just as the moral role of medicine can be seen to be to produce net (health) benefit with as little harm as possible in ways that respect the autonomy of all potentially affected and in ways that are just or fair (a sort of medical mission statement), so perhaps the moral role of government is to produce for the people it governs net (overall) benefit (beneficence) with as little harm as possible (non-maleficence) in ways that respect the autonomy of all potentially affected (respect for autonomy) and in ways that are just or fair (justice). That would be not a bad governmental moral mission statement, though I say it myself! So how would improved consultation help to fulfil such a moral mission statement?

Beneficence and non-maleficence

Beneficence and non-maleficence are necessarily considered together in contexts where the objective is to produce benefits, for whenever one tries to produce benefit one always at least risks producing harm and sometimes one necessarily produces harm. Given that one of (perhaps the main?) moral objectives of government is accepted to be the production, for the people it governs, of net benefit with as little harm as possible, it becomes important to consult those whom one wishes to benefit. Why? In order to discover what those people consider to *be* benefits and what they consider to be harms, and the degree of importance that they attach to those benefits and harms. Thus, just as doctors are (these days!) expected to consult their patients about what those patients consider to be harms and benefits and how important those harms and benefits are, so governments can reasonably be expected to consult the populations they represent and govern on what those populations consider to be harms and benefits and how beneficial or harmful they consider them to be. One of the moral functions of improved consultation in the NHS can therefore be interpreted to be to discover which activities in the health field are considered to be beneficial and which are considered to be harmful, and to attempt to determine the weights attached to those harms and benefits by the population.

Respect for autonomy

Quite apart from its role in improving the production of benefits and reducing the imposition of harms, respect for autonomy is widely regarded as an important moral principle or value across a wide range of moral, religious, and political theory. Moral agents generally wish to rule themselves – and to be allowed to rule themselves – on the basis of their thought out or deliberated choices for themselves, and where they cannot thus rule themselves the next best thing is to have reason to believe that their views on how they are to be ruled by others (whether those others are car mechanics, doctors or governments) are listened to and as far as is reasonably possible (for there are of course all sorts of constraints) acted on. Consultation in the NHS also therefore helps to further the moral objective of government to respect the autonomy of the people it governs.

Justice

The fourth plank of my putative moral mission statement for government was that it produce its benefits for the people it governs in ways that are just or fair. Now while people have *fairly* clear ideas about what for them constitute benefits and what constitute harms, and *fairly* clear ideas about their grading of harms and benefits; and while they have *fairly* clear ideas about what constitutes respecting their thought out or deliberated choices for themselves, I don't believe that people are at all clear about what they mean by justice – or by 'ways that are just or fair'. And even when they are clear about what they mean they will usually find that others who have clear views nonetheless understand these terms somewhat differently. Indeed, should we ask (as we have seen at a previous meeting of the Health Equity Network) what do we mean by 'ways that are just or fair' or by 'justice', I am

sure we would come up with many different and mutually inconsistent accounts. We'd probably all be able to agree with Aristotle that justice or fairness requires us to treat equals equally, and unequals unequally in proportion to morally relevant inequalities (horizontal and vertical equity, to use the health economists' language) – but we would almost certainly disagree about what *were* the morally relevant equalities and inequalities, and on how to incorporate them into a substantive as distinct from a formal account of justice. For example, in the context of distributive justice in health care, while we would almost certainly agree that we should distribute limited health care resources in proportion to need (distinguishing this from mere desire), we would also almost certainly disagree about whether this was the only morally relevant criterion or whether (and if so how) we should also incorporate other and potentially conflicting criteria such as welfare maximization per unit of resource (not forgetting the intrinsic tensions within this one criterion), respect for the autonomy of the various 'stakeholders' (not forgetting the effects that such respect might have on equality of opportunity and on equality of outcome, themselves in obvious tension if both are included in a substantive theory of justice). And there are other putative candidate criteria. We have considered such issues before and acknowledged their complexity (Oliver et al, 2001).

Moral rationales underpinning consultation exercises

So how might public consultation contribute to a government's moral objective of providing its benefits justly or fairly? One obvious way is by seeking the views – the deliberated views – of 'the governed' about what they believe constitutes such justice or fairness – about what they believe *should* be considered morally relevant criteria by government when deciding on their behalf how best to allocate limited resources for health care, and why. A second and obviously related way is to ask 'the governed' to look at various practical examples and decide how to allocate the scarce resources, and to give their reasons for their decisions.

Thus as a 'four principles' medical ethicist – and I should of course add a health warning here, for many contemporary medical ethicists now reject 'principlist' approaches – I would accept all the 'respectable' sets of values that Weale gives as providing rationales for public consultation. I would simply propose that the rather disparate set of rationales are themselves morally underpinned by various combinations of the four *prima facie* moral principles that I have outlined. Let us accept that the Westminster model is arguably more likely to produce stable and effective government, and that it is more accountable to the electorate at each election for the totality of its actions in government than a (proportional) representation model (what I called a consultative model). Let us also accept that the Westminster model arguably tends to give less intrinsic or structural weight to consultation of the different viewpoints represented in the electorate. Then one obvious objective of the Westminster model should be to at least try to remedy this structural aspect of the democratic deficit by consulting the range of viewpoints that exist within the population that has elected the government. Why obvious? Because by doing so it is more likely when in government to carry out policies that will lead to its re-election. But quite apart from such political self-interest I have suggested that governments (of whatever democratic

model) may have some general prima facie moral obligations, summarized in my proposed moral mission statement – the provision for the people they govern of net (overall) benefit (beneficence) with as little harm as possible (non-maleficence) in ways that respect the autonomy of all potentially affected (respect for autonomy) and in ways that are just or fair (justice).

If this governmental moral mission statement were accepted then Weale's various rationales for consultation can themselves be morally underpinned by their contribution to this governmental moral mission, itself reflecting the four fundamental moral concerns. Thus, his first rationale is the identification of competing perspectives on issues, particularly in respect of their moral dimensions. This seems to fit well within both the pursuit of benefits with minimal harm (because people have different perspectives on what constitute benefits and harms and of their relative importance), and within the endeavour to respect people's autonomy. In the latter context there is emphasis on finding out not only what people's opinions are, but also why they have them – i.e. on finding out what their *deliberated* views are. One of the common characteristics of the various consultation experiments described by Weale (focus groups, citizens' juries, consensus conferences, community forums/panels, and deliberative polls) is their emphasis on the need for deliberation, a need easily explained if the moral underpinning is seen as respect for people's *autonomous* decisions rather than respect for *mere* decisions or *mere* choices (their mere choices may of course be the decisions that are respected in the election process itself – that depends on how much deliberation the individual elector puts into his or her vote – but the consultative process should not, on this moral analysis, content itself with ascertaining *mere* choices, as it should seek deliberated choices and their rationales).

Weale's second rationale for consultation is "rectifying an imbalance of political influence", giving the public more input to the governmental decision making process to remedy the existing disproportionate political influence of, for example, "concentrated producer interests" (and, one might add, any other political lobby groups). This rationale seems plausibly underpinned by the moral objective of justice or fairness – assuming that whichever substantive theory of justice is used it will seek to treat all people within an electorate as equals in relation to their right to have their views considered by those who govern them.

His third rationale for consultation is "improving the technical quality of decisions". Given the example offered (the accurate perception by local farmers of effects of radiation on their sheep in the Chernobyl fall out area) one may infer that the main moral underpinning of this rationale is the pursuit of benefits with minimal harm. In order to make decisions that will be most beneficial and least harmful, the information underpinning those decisions must be optimal. As wide a range of relevant expertise as possible must be sought, and wide consultation can contribute to this.

Weale's fourth and fifth rationales for consultation are once again easily morally underpinned by the pursuit of respect for autonomy. Thus, the "publicity condition in a democracy", while it may also contribute to achieving benefits with minimal harm, is surely a way of governments explaining to the people they govern what they have done or (better)

propose to do and why. The consultation process affords a way of finding out how acceptable these governmental decisions and their rationales are to the people they govern (of course, this leaves open, as Weale points out, the question of how representative the groups consulted are of the ‘governed’). Similarly, the “legitimacy” rationale seems best underpinned by the objective of trying to respect the autonomy of the people governed – though surely such legitimacy does not necessarily, or even at all, require referenda (the example given by Weale). As he points out, the consultative process need not be the decision making process.

Two implausible rationales?

Weale also rejects as implausible two rationales for consultation that may – on my moral analysis – be more morally justified than he argues, though I readily confess that I may simply be misunderstanding at least the first of these, the “provision of information on the social welfare function of a society”. He explains that a “social welfare function is a mapping of a statement of individual preferences over alternative social states into a statement of collective preferences”. Thus, he goes on, public consultation about the relative value that individuals place on various combinations of disease/disability states might (but erroneously, he concludes) be thought of as providing such information. This is erroneous in that the information provided is not reliable. I am not clear why such information is less reliable than information according to the first of his rationales (“identifying competing perspectives on issues”), but if the point is simply that there are more reliable ways of finding out about the relative values that the population as a whole places on competing health states – for example, well designed surveys – then we are not at odds. However, the rationale for the *objective* of finding out what the people who are governed prefer and why they have those preferences remains a morally valuable one, underpinned both by the putative governmental moral objective of providing (optimal) benefits with minimal harm, and by the putative governmental moral objective of seeking to respect people’s autonomy.

The second allegedly implausible rationale for consultation is “avoiding unnecessary confrontation and creating the conditions for consensus”. His objections are that “there is no reason in general to think that public consultation will always issue in a consensus” and that too much striving for consensus may undermine “the sort of Popperian critical rationality that may be important for progress”. But surely his objections are entirely compatible with the rationale, provided only that this is understood as *an attempt* to avoid *unnecessary* confrontation and an *attempt* to create the conditions for consensus. After all, it is at least sometimes the case that deliberation and reflection on opposing views will result in reducing “unnecessary confrontation” and even in consensus. But of course, confrontation may sometimes be necessary and consensus may not be achievable. Yet here too consensus can properly be sought, though at a different level, notably at the procedural level of deciding about how governments *ought* to deal with irresolubly conflicting positions within the populations governed. Once again the quest can be seen to be morally underpinned by the governmental moral objective of justice or fairness. Once again, consultation with the people governed, especially given both the lack of clarity and – where

there is clarity – the disagreement about the appropriate content of substantive theories of justice, seems in itself to be a positive contribution to the pursuit of justice in government.

To conclude, given some such governmental moral mission as the one I propose, based on those four widely acceptable moral objectives, public consultation can be seen to be a morally highly desirable activity by government. So much so indeed that, without in any way undermining the legitimacy of the Westminster accountability model of government that led to its creation, the present Government can be encouraged to experiment with and develop more and better methods of such public consultation.

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A comment on Weale’s paper from an economics perspective

Hugh Gravelle¹
University of York

Weale’s paper discusses the rationale for public consultation in the Westminster political model in which the health service is run from the centre by a national government accountable to the electorate in national elections. I will not comment directly on his arguments about consultation but will address a prior question prompted by his paper: “Why Westminster?”. As Weale notes, there was some debate when the NHS was founded about whether the health service should be accountable to local or central government before Bevan’s centralist view prevailed. I will discuss some of the economic rationales for central rather than local control and suggest that they are by no means compelling. I will also try to bring out some of the implications of central versus local control for equity. I will not be specific about the level at which local political accountability would reside in a decentralised system (local authority, regional government or possibly elected local health providers akin to primary care trusts or health authorities).

Local variations in tax bases, needs and costs

Areas differ in their needs for health care, in the unit costs of inputs required to produce health care and in their tax bases. If areas had to finance local health services by local taxation there would either be geographical inequality in taxation or unequal provision relative to need. But, as with local government finance, there is nothing to prevent central

1. I work in the National Primary Care Research and Development Centre (NPCRDC) at the University of York. The NPCRDC receives funding from the Department of Health, but the views expressed in this paper are not necessarily those of the funders.

government using national taxation to raise funds to be redistributed from richer to poorer areas to equalise the tax burdens on their populations. The current system of resource allocation can be regarded as a means of attempting to redistribute funds from national taxation to ensure equal provision across areas for equal need. Central government can take responsibility for the overall level of resourcing and local government for the provision of services from the resources provided by a national resource allocation formula funded from general taxation. Such formulae can also allow for differences in the costs of providing a given level of service for a given level of need due to differences in input prices or because of differential access costs for patients. Local differences and local control do not necessarily imply geographical inequality in taxation or in provision. Nor, as the history of the NHS shows, does half a century of central government control lead to geographical equality in provision, of utilisation or of outcome.

Market power

One argument for central control is that a single purchaser of health care inputs can capture gains from the exercise of market power for the benefit of patients or taxpayers. Such gains can arise for two reasons. First, even in competitive input markets, the fact that there is deadweight loss from taxation means that the quantity purchased should be less than the level that would equate the monetary value of the health gain from an additional unit of an input to the market price of the input. Second, many of the inputs required for health care are purchased in markets where suppliers, whether pharmaceutical companies protected by patents or powerful unions, have market power. National bargaining can reduce the cost of producing a given volume of health care compared to a situation in which local purchasers merely accept the prices set by monopoly suppliers.

These arguments suggest a case for national, rather than local, bargaining, but they apply to the fixing of prices and wages, not to the provision of services produced by the inputs bought at those nationally set prices and wages. Note also that efficient pricing of inputs does not necessarily mean uniform pricing. In labour markets the fact that different areas are not equally attractive to workers means that pay rates must differ to ensure the same level of provision. Equality of provision requires inequality in wage rates. National pay bargaining could in principle yield such appropriate geographical variations in pay but the experience of national pay bargaining suggests that pay rates are not sufficiently sensitive to local variations. Consequently areas like London where workers face high housing and other costs have shortages and other more attractive areas have no recruitment problems. Local bargains might adjust wage rates more finely to local labour market conditions. However, if the resource allocation system fully compensates areas for differences in input prices, then local bargainers have an attenuated incentive to bargain for lower wages and prices since they can pass the cost onto taxpayers in all other areas.

Externalities and public goods

There are some decisions with consequences which affect the health of citizens in all areas and hence require central control. Obvious examples include infectious and contagious

disease control and policies to regulate some forms of environmental pollution, such as nuclear waste disposal. But by no means all public health decisions create national public goods. Many affect only local populations: water fluoridation and regulation of food hygiene in shops and restaurants are examples.

The most important form of public good in health care provision is information about the costs and effects of health technologies. Once the costs of evaluating alternative technologies have been incurred, the costs of disseminating the information are effectively zero. Hence there is a strong argument for central control or coordination of the production of information for health decision makers. But this does not imply that decisions made on the basis of the centrally produced or funded information have to be made centrally.

Indivisibilities and economies of scale

There are economies of scale in the provision of some types of health services. Economies of scale and the spatial dispersion of patients inevitably imply inequalities in access. Efficient service provision which minimises the sum of NHS and patient costs will imply that some parts of populations must face significant distance costs in using the service. The danger with local decision making is that the effects of decisions on service location will not take account of their impact on populations in other political jurisdictions because local politicians are accountable to local electors. Facilities may be sited in the wrong place or there may be an inefficient proliferation of facilities. A suitable system of pricing for cross-boundary flows will reduce such inefficiencies but seems unlikely to eliminate them. On the other hand a system of central accountability in which local communities do not bear the full costs of facilities in their areas also has obvious drawbacks.

Information asymmetry and inequality

The main argument for decentralised decision making is that local decision makers have greater knowledge of the health needs of their populations and of local conditions affecting the production of care than national decision makers. However, although local control can lead to greater health gains in total, it may increase or reduce inequity compared with a system in which the centre exercises tight control over within-area allocations.

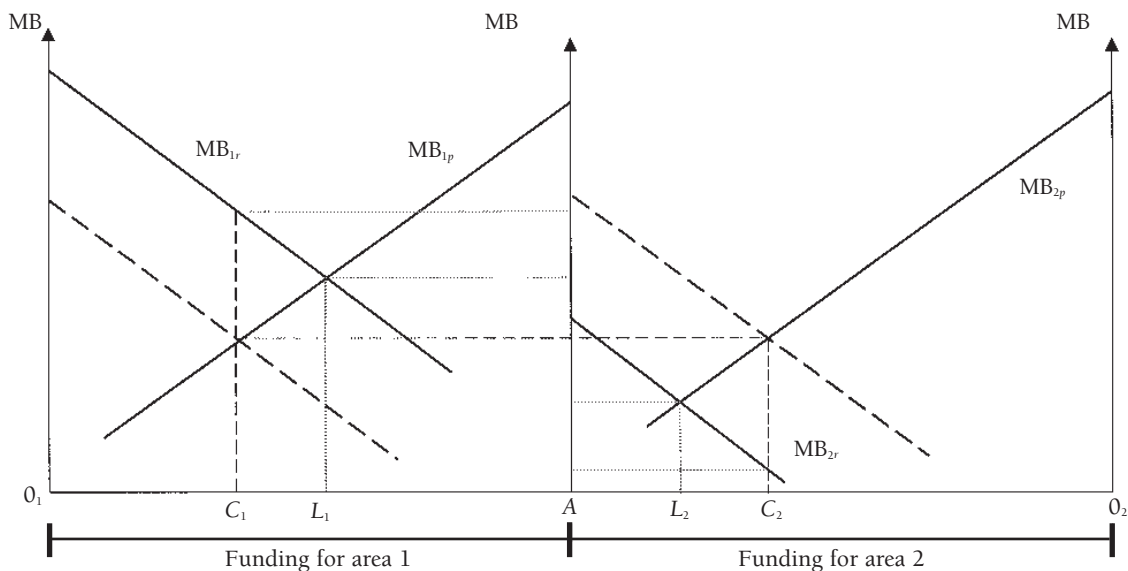
Consider Figure 1, overleaf, which illustrates a very simple health economy. There are two areas and two types of people in each area. There are equal numbers of both types in both areas and each area has the same total population. Each type has a marginal social benefit from health care. The central Department of Health (DH) has perfect information about the marginal benefits to type p individuals, shown by solid marginal benefit curves MB_{1p} , MB_{2p} for type p in areas 1 and 2. Suppose, for the moment, that the DH also has perfect information about marginal benefits for type r individuals in the two areas and that these are shown by the dashed lines.

The DH has a given health care budget to allocate across the two areas, shown by the length of the horizontal line between O_1 and O_2 . The amount of funding for area 1 is measured

rightward from 0_1 to A and that for area 2 leftward from 0_2 to A . Within area 1 the amount of funding allocated to type r is measured rightward from 0_1 and that to type p leftward from A . Similarly, in area 2 allocations to type p are measured leftward from 0_2 and to type r are measured rightward from A . Notice that the marginal benefit to type r is less than the marginal benefit to type p in both areas. If we define need for health care as capacity to benefit, the lower marginal benefit curves of type r can be interpreted as showing that the population of type r individuals have less need for health care than the population of type p individuals.

The marginal benefit curves embody judgements about the magnitudes of health gain from health care and the relative social value of such gains for different types of individuals. An optimal allocation of resources across areas and across groups is one which maximises total social benefit. If the DH has perfect information on the marginal benefits of both types in both areas, central government control can achieve a first best optimal allocation. Funds would be allocated within areas so that the marginal benefits to each type are equal, and funds would be allocated across areas so that marginal benefits to each area are also equal.

Figure 1. Equity under local and central control



Central control – type p : horizontal equity; type r : high horizontal inequity; vertical inequity within areas
 Local control – type p : horizontal inequity; type r : low horizontal inequity; vertical equity within areas

In Figure 1, the optimal allocation, when the true marginal benefit curves for type p are the solid MB_{1p} , MB_{2p} lines and for type r are the dashed lines, is defined by the points A (fixing the allocation between areas) and C_1 , C_2 (fixing the shares of area allocations 0_1A , $A0_2$ received by each type in each area). In these happy circumstances there is horizontal equity across areas: individuals of the same type are treated equally across areas in that a marginal pound allocated to a given type of individual yields the same marginal benefit in the two

areas. Moreover, there is vertical equity: marginal benefits of health care expenditure are equal across types within areas. Because type r have lower marginal benefits than type p they have less funding allocated to them: there is appropriately unequal treatment of those in unequal need. In this first best world where the centre knows as much as the local decision makers, the optimal allocation could be achieved by full central control or by the centre making the optimal allocation between areas (choosing point A), secure in the knowledge that local decision makers will then allocate optimally within areas between types.

Now consider the more realistic second best world in which the DH does not know the true marginal benefit of type r individuals and let the dashed lines now be the expected, or national average, marginal benefit curve for the type r . The true marginal benefit curves for type r in the two areas are given by the solid lines MB_{1r} , MB_{2r} but the DH does not know where the true curves lie. Local decision makers, on the other hand, do know the location of the marginal benefit curves for all types in their area.

Under a fully centralised system the DH chooses the allocation of funds between areas and the allocation within areas between types of patient. In a decentralised system there is local control over the allocation of funds within areas. Under the fully centralised system the best the DH can do within areas is to allocate funds to types to equate the expected marginal benefit to type r to the marginal benefit to type p . The within-area allocations are C_1 , C_2 . The DH allocates funds across areas to equalise the expected marginal benefit from spending with O_1A to area 1 and AO_2 to area 2.

With local control within areas the DH would make the same allocation between areas on the basis of its expectations about marginal benefits. But the local decision makers, who know the true marginal benefits, would allocate their funding to equalise marginal benefits across types within areas: $MB_{1r} = MB_{1p}$, $MB_{2r} = MB_{2p}$. The allocations within areas if there is local control are at L_1 and L_2 .

In a first best world where the DH knew that the true local marginal benefit curves of type r were represented by the solid curves MB_{1r} , MB_{2r} it would shift resources from area 2 to area 1 (shifting point A), and the within-area allocations would also change. But given that the centre does not know the true marginal benefit curves for type r the best allocation across areas is at A.

In the second best world with local decision makers being better informed than central decision makers, local control gives a greater total benefit than fully centralised control because resources within areas are shifted to patients with high marginal benefits and away from those with low marginal benefits. Central control of within-area allocations leads to too little resource going to type r and too much to type p in area 1 and vice versa in area 2.

The implications of local control for equity are less clear. Local control leads to vertical equity within areas (type r and p have the same marginal benefit) but across areas there is horizontal inequity for each type: $MB_{1r} > MB_{2r}$, $MB_{1p} > MB_{2p}$. Central control within areas leads to vertical inequity within areas: $MB_{1r} > MB_{1p}$, $MB_{2r} < MB_{2p}$. There is no horizontal inequity under central control for type p whose marginal benefit curves are observed

perfectly: $MB_{1p} = MB_{2p}$, but there is horizontal inequity for type r : $MB_{1r} > MB_{2r}$, and such inequity is greater than the horizontal inequity for type r under local control.

Conclusion

The considerations I have sketched out (albeit very briefly) do not suggest an overwhelming case for centralised decision making in the NHS, but they are primarily arguments about the locus for decisions rather than for political control. A discussion about whether local or national politicians should be accountable for the health service requires application of a positive model of political economy and public choice to compare local and national political control.

EQUITY AND CHOICE: CAN THE NHS OFFER BOTH? A POLICY PERSPECTIVE

Simon Stevens
10 Downing Street

In the current UK health reform debate it is frequently asserted that more patient choice would mean less equity. Here I suggest this popular nostrum could be wrong and sketch an argument in favour of more choice.

First the caveats. My argument is not that more choice necessarily increases equity – simply that the opposite is not true either. Given our starting point, choice in the NHS can be expanded significantly without facing an equity trade-off. But the devil will be in the detail of the choice mechanisms used.

Nor is my argument that consumer choice will be appropriate in all circumstances. But because it is difficult for emergencies or double-edged for some integrated chronic disease care, it does not follow that it should be ruled out for maternity services or elective surgery, for example. This becomes obvious when comparing the limited nature of UK patient choice with that offered by other high equity health care systems – be they tax-funded or social insurance-based – such as Denmark or the Netherlands (van Doorslaer et al., 2000).

Nor should choice be the only, or even principal, driver of improvement. Explicit standards, external review and inspection, sharing of best practice and cultural change are all necessary (Department of Health, 1998; 2003a). But incentives matter too. And by empowering consumers, as the Scandinavians have shown, carefully structured choice mechanisms can help create positive incentives on producers to expand appropriate output efficiently while improving responsiveness to patients. Such then are the caveats. What of the objections?

Objections

Resources

What of the claim that the extension of choice is incompatible with a resource-constrained health service? Of course, there are limits to choice. But it is possible to split the ‘entitlement’ decision from the ‘choice of provider’ decision. Primary Care Trust commissioners can, within fixed budgets, shape priorities and decide whether an individual patient is entitled to NHS-funded care. Once that decision has been made, patients could then freely choose between externally-regulated providers who are reimbursed using the new NHS fixed tariff. And just because entirely open-ended choice of treatment is impossible, it does not follow that there can be no choice of treatment. Increased choice can also be exercised as to when and where, how and by whom care is provided.

Capacity

It is often said that choice of provider requires ‘spare capacity’ lying idle for the marginal patient. Yet, as a minimum, all choice requires is differences between providers in their ability to bring new capacity on stream in response to extra demand; or differential length of queue to choose between – allowing patients to make their own trade-off between speed of access, geographical proximity, and other aspects of care.

Efficiency

Even in a capacity-constrained system, choice can help drive efficiency by providing a structured way of moving ‘excess demand’ to areas of new ‘supply’. Furthermore, where provider prices are locally negotiated – as at present – the willingness of patients to go elsewhere can help control price inflation by weakening the pricing power of incumbent local provider cartels. And in future, when providers are reimbursed at a fixed NHS tariff rate, patient choice will mean they are incentivised not only to increase volume, but also to reduce waiting times and improve other dimensions of care valued by patients.

Information

Some argue that the offer of universal choice will fail because of a lack of information on the options. But by quality-assuring all providers, the new public and private health care inspectorate (CHAI) should mean that patients can be confident of reasonable standards wherever they opt to be treated. And CHAI itself will become a key source of objective information on health care providers. It is also likely that the very fact of introducing choice will be the spur to the expansion of information on which to base those choices. In the meantime, where the NHS has offered choice of elective surgery provider, patients have shown conclusively that they are willing and able to switch providers on the basis of the information available to them. Nearly half of cardiac patients and two thirds of cataract, general surgical and ENT (ears, nose and throat) patients, choose to do so (Department of Health, 2003b).

Choice and equity

But what about equity? Is it the case, as some assert, that choice inevitably involves a trade-off against equity, and that this is too high a price to pay? Unless they somewhat

implausibly suggest that the NHS happens to have stumbled upon precisely the optimal blend of choice and equity, the corollary is that those who think choice leads to unacceptable reductions in equity presumably favour reducing what little choice there already is in the NHS. That women, for example, should revert to being denied even limited choice over where they give birth and how? Or the dying be denied even a measure of say in their palliative care? Or patients no longer having at least putative choice of GP, and so on?

By contrast, I suggest that it should be possible to extend choice in publicly funded services – and in particular the NHS – in such a way that choice actually promotes equity.

We have to start with honesty about the status quo, and two uncomfortable realities stand out.

One – that our supposedly uniform public services are in fact inequitable. Despite the relative absence of financial barriers, NHS care is often still skewed by class, ethnicity, gender and geography. And thanks to performance data we now know that health services are of highly variable quality, often with poorer people receiving worst services (Acheson, 1998).

Two – that richer, better-educated people *already* have choices, including the choice to buy their way out of failing public services (Besley et al., 1999), which they are indeed doing in significant numbers. In parts of England a fifth of routine surgery is privately funded.

So we do not start from a position of high equity and low choice. We start from a position of partial equity and class-based choice.

This points to the first reason why more choice could be more equitable; namely that universal choice gives poorer people some of the same options currently available only to the middle classes. This matters where individual needs and preferences are heterogeneous. And it redresses the current inequity by which only better-off people can choose to switch from under-performing providers. However, special effort will be needed in designing the choice mechanisms to ensure it is used by socially excluded groups too (while accepting that ‘deciding not to choose’ is also a valid choice). That is why the NHS is developing ‘proactive’ choice – investing time and effort in explaining people’s options and supporting them in their decisions.

Second, choice can improve equity by putting pressure on the low quality public providers that poorer people are often forced to rely on. Richer people sometimes argue that poorer people don’t want choice – they just want fast, good quality services. Even *if* this was true, and individual preferences were indeed homogeneous, this argument misses the point that choice can create precisely the grit in the oyster to help ensure providers offer these fast, high quality services. As far back as 1950, Nye Bevan noted the risk of ‘producer capture’ within the NHS:

“... there are a vast number of pressure groups which are concerned; there are the doctors themselves, then there are the nurses, then there are the domestic staffs of the hospitals, then there are the dentists who are particularly vocal, then there are the ophthalmic opticians, then there are the various other bodies, and then of course there are the hospital

administrators, also an extremely powerful presence. One after the other takes the stage and makes its presence known until before very long one gets the sort of impression that the National Health Service is being created for them and the poor patient is hardly heard at all.” (Webster, 1991)

Patient choice is potentially an important stimulus – though not the only one – in helping to ensure that health care providers place sufficient weight on the needs and preferences of their users, rather than those of their own institution.²

This in turn gives rise to a third potential equity benefit from choice. It is that by improving service responsiveness, choice sustains social solidarity by keeping better-off patients within the NHS. The hypothesis is that the willingness of better-off groups to support increased progressive taxation to fund an equitable and collective NHS risk pool will be weakened if, through lack of provider-side responsiveness, they opt out of publicly funded care. So diversity and choice on the supply side may cement equitable funding pools on the demand side. Without this, the argument runs, there will be a gradual erosion of collective usage and the slide to safety net services for the poor – as previously seen in many inner city comprehensive schools.

Of course the old argument against allowing choice (‘exit’) was that it forced the middle classes to push for better standards in local monopoly public services (‘voice’), the benefits of which would then trickle down to poorer users. But unless private spending on health and education were outlawed, the ‘forcible voice’ strategy will become decreasingly effective as disposable incomes rise, so enabling more people to opt out of publicly funded services and pay privately.

Conclusion

In summary, more patient choice is possible, even within a resource and capacity constrained NHS. It is likely to be valued by patients. If properly structured, it could improve efficiency. And giving NHS-funded patients more choice could improve equity, since it would give poorer people options that are currently the preserve of the better-off; could stimulate better performance from providers currently relied on by deprived communities; and could help sustain public support for universal tax-funded services available on the basis of need not ability to pay. The challenge now is to design the specific choice mechanism to unleash this potentially virtuous combination of benefits.

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2. This stimulus is progressively being introduced in England with – amongst other measures – the introduction of patient choice of provider starting with surgical patients who have waited a defined period; the introduction of new surgical Diagnostic and Treatment Centres; and a new fixed hospital tariff system in which money will actually follow the patient.

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