

original article

Ethical implications of introducing patient choice in the National Health Service in England

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Patient and user choice is at the forefront of the debate about the future direction of the provision of health and other public services in many industrialised countries (Beusekom Tonshoff, de Vries, Spreng, & Keeler, 2004; Williams & Rossiter, 2004). Specifically, in publicly funded and provided health care systems, where choice has been, or is perceived to have been historically lacking, increasing it has become a key policy objective (Ashton, Mays, & Devlin, 2005; Vrangbæk, Robertson, Winblad, van de Bovenkamp, & Dixon, 2012). Promoting market-based individual patient choice, first introduced in the 1990s, has now become a standard health policy objective in the National Health Service (the NHS) in England. The passing of the Health and Social Care Act 2012 (Department of Health, 2012), means that this trend is set to continue.

The idea of patient choice in health services is founded on two general assumptions: one is that it will aid competitive markets in their tasks to improve the efficiency of providers as well as improve quality; the other is that the exercise of choice is an important good in itself for patients. But the assumptions on which the policy rests have been found wanting (Fotaki et al., 2006; Greener, 2008). Their applicability is either severely limited or invalid when applied to health care, for both theoretical and empirical reasons. The paper discusses these limitations and then explores the ethical implications of introducing market-based patient choice in health care.

The limitations of the market-type patient choice in health care

First, the necessary theoretical pre-conditions rarely apply in health care since health is not a commodity that can be easily sold and exchanged. Health care markets are rarely competitive, and patients often lack information needed to make choices although patients with long term conditions may be more able to make informed choices (Singh & Ham, 2006). The narrative of knowledgeable users of public services exercising their preferences via acts of consumption overlooks something that is actually central to health care choice in real life: the patient's need for trust-based relationships with care providers (Taylor-Gooby, 1999). Precisely because patients lack the information needed to make informed choices about their care, they need medical professionals they can trust; this overrides their desire to 'shop around' (Fotaki, in press). Even in material markets people are seldom rational choosers and least of all in relation to health services (Ferraro, Shiv, & Bettman, 2005). Individuals do not always choose what is in their best interest even if they are able to identify it (Hoggett, 2001) – allowing them to make decisions which are acceptable to them but which may not be entirely rational - a reality that economists have now come to acknowledge (Thaler & Sunstein, 2008). For patients, the severity of their medical condition amplifies the bias in processing information that the human mind is prone to even further (Kahneman & Tversky, 1979).

Second, choice means different things to

different or the same people at various points in time because users of services share multiple identities as citizens, family and community members, members of religions, and much more. Patients' ability, and even their willingness to make choices, is influenced by their beliefs, cultural values and expectations as well as their life circumstances, personal characteristics and their experiences of health care services (Fotaki, et al., 2008). Put differently, the individual choices we make are socially constructed (Pescosolido, 1992).

Third, patients do not seem strongly attracted to the idea of consumerist market choice in health care. Thus a recent review of choice in public services in the UK found that only 35 percent of patients exercised choice of hospitals (Boyle, 2013). What mattered more to patients was obtaining information about their treatment (Picker Institute Europe, 2007). Although generally positive about having choices, the most important aspects from patients' points of view concerned their involvement in treatments rather than hospitals or providers (Coulter, 2010). In reality, patients were able to choose between hospitals and appointment times rather than primary doctors, hospital consultants and treatments. The ability of a patient-consumer to assess the quality of medical services received is for many types of treatment is thus limited to such relatively peripheral issues as waiting time, comfort of waiting rooms and wards, and friendliness of staff, which they can use as a proxy for information to exercise choice. Fourth, introducing consumer choice might alter the meaning of trust in different situations in health care and damage the legitimacy of the service through eroding public's trust in the system such as the NHS (Taylor-Gooby & Wallace, 2009).

Overall, personalised choices are in conflict with the collective goals of public health systems (equity and efficiency) as more

resources are likely to be needed to meet individualized patients' wants at the expense of equal availability of services to all (Oliver & Evans, 2005). This can happen either because some patients receive preferential access and treatment under certain schemes (as was the case under the internal market in the UK with the patients of GP fund-holders obtaining a preferential access to hospitals with shorter waiting times) (Mannion, 2005) or because physicians are likely to modify their behaviour in order to fit the market, which could benefit some patients more than others. Such outcomes are incompatible with the goals of universal health care systems.

Last but not least, introducing market incentives of competition and choice is likely to have important implications for not only changing the ethos of public services but also for ethics of care underpinning patient and doctor/nurse interaction. The latter might be the effect of moderating health professional behaviours after introducing markets incentives when they are expected to respond and report on financial and other targets rather than devote time and energy to provide care services to the patients. The widely discussed Francis Report (2013, p. 4) caused alarm amongst regulators and central government alike, identifying "the need to change a culture focused on doing the system's business - not that of patients". A key lesson and ethical implications from Staffordshire hospital's tragic neglect of patients care are discussed next.

The ethical implications of introducing markets in health care: The case of the Mid Staffordshire NHS Trust

The Mid Staffordshire NHS Trust failures in

rudimentary aspects of care and the widespread and systemic patient abuse taking place in this instance (involving leaving dying patients hungry, soiled and in pain for hours see -Donnelly, 2013) is extreme but not unusual. While the hospital's management embarked on cutting costs in this specific case, the staffing requirements needed to provide adequate patient care, and arguably the patients themselves, were ultimately seen as 'getting in the way' of achieving the hospital's strategic goal. This has also been shown to be a direct result of giving priority to demonstrating 'financial health' which was a necessary precondition for achieving foundation trust status by the hospital. The Francis Report provides a damning indictment of such an approach: 'While the system as a whole appeared to pay lip service to the need not to compromise services and their quality, it is remarkable how little attention was paid to the potential impact of proposed savings on quality and safety' (Francis Report, 2013, p. 45).

But how could managers or even the frontline staff distance themselves from the obvious task of providing care to the point of criminal negligence? Though moral responsibility for any action rests ultimately with the individual, the widespread failing in care standards cannot be simply attributed to callous and uncaring staff. In order to understand why this happens we must move beyond simplistic frames taken from economics pointing at self-interest as a single key driver of human behavior. Some recent research in clinical psychology suggests how almost anyone might engage in unethical behaviour, thanks to a complicated and socially reinforced mix of organisational and individual factors having to do with mental framing, perceptions and unconscious motives (Bazerman & Banaji, 2004).

Organisational research confirms that when explicit targets are coupled with a strong

incentives (and/or disincentives), people will strive to meet them often at the expense of a common sense (Schwartz, 1987). This could sometimes even lead to them violating socially accepted norms (Fotaki & Hyde, 2014) as they are working towards meeting impersonal organizational targets (Ferlie, McGivern, & FitzGerald, 2012). Indeed, the findings from the Francis Report confirm the absence of 'a sufficient sense of collective responsibility or engagement for ensuring that quality care was delivered at every level' (Francis Report, 2013, p.44). Managers and organisations are critical to the creation of an ethical environment but the overall policy framework in which they operate is even more important. Therefore, providing adequate training proposed by the UK government on its own is unlikely to be an effective way of ensuring that nurses and doctors treat their patients with compassion given that they will be introduced at a time when new competitive pressures are being introduced to the health service. The evidence from the USA suggests that combining marketisation with cost-saving mechanisms has reduced trust in the health system and physicians (Rhodes and Strain, 2000; Mechanic, 1996), who report that they are less able to either avoid conflicts of interest or put the best interests of patients first (Feldman, Novack, & Gracely, 1998). Although probably less pronounced than in the USA, a decrease of patient trust in response to physicians modifying their behaviours to fit the market has been observed in Sweden (Bergmark, 2008) and the Netherlands (Dwarswaard, Hilhorst, & Trappenburg, 2011) following the introduction of competition and choice. Codes of ethics along with the lengthy socialisation process into the norms and values of the profession might be difficult to adhere to when resources are squeezed and the norms and values are altered.

Conclusion: Market choice and the logic of care

Consumerist choice, aiming to substitute for interdependency and care in health services is far removed from the lived materiality of bodies and the logic of care. In the absence of a caring professional, choice and information are utterly ineffective to the point of being useless. This is not to say that patients are not interested in receiving relevant and usable information about their treatment, but to stress the role of relationality in care situations. Although offering patients' choice appears to be what patients want however, but this does not necessarily translate into desire for a consumerist system but rather a partnership with their clinician where the knowledge of the expert is utilised by the patient. Derived from early 20th century theories of consumer demand and neoclassic economics, the prevailing logic of choice assumes that patients act as calculating and rational utility-maximisers even though people are known to not generally behave as economic models predict. When making complex health decisions, patients rely on their intuition and emotions involving the avoidance of regret as well as trusted networks, rather than objective, impersonal data (Ryan, 1994).

Patients' need for relational aspects of care (Mol, 2008), that do not easily fit with consumerist ethos of the market choice, is disregarded in recent reforms which promote it. Although it is possible to treat people who seek professional help as customers this is incompatible with ways of thinking and acting that are crucial to health care. Good care grows out of collaborative and continuing attempts to attune professional knowledge and technologies to diseased bodies and complex lives (Mol, 2008). Framing the issue of choice in the context of market competition roots it in old-

school neo-classical economics and involves a significant narrowing of the concept of choice, and of the users of health services as rational 'choosers' exercising their preferences. Choice and independence are indeed powerful concepts, but interdependency is an essential part of social life and never more so than in the times of illness and vulnerability.

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