NUFFIELD COUNCIL ON BIOETHICS

Forward Look 2014
13 May

The ethical implications of resource pressures in the NHS

Introduction

The forward look session on the ethical implications of resource pressures in the NHS began with presentations from invited speakers and respondents, followed by a debate among other assembled guests, including Council members and secretariat. This note summarises the presentations and themes that emerged during the meeting, as well as the discussion on the potential role of the Council in approaching these. Views expressed are those of individuals are not necessarily shared by others present, or the Council

Presentation 1: NHS funding pressures: some ethical questions

The presentation outlined the context for approaching ethical questions by describing the financial situation the NHS is facing until 2021/22, the impact of current austerity measures on quality and access to care, as well as strategies and techniques that might be used to raise funds and 'manage demand'.

Historical background vs. current situation:

- Real terms NHS spending has been growing on average around 4% since inception, and the overall plan in later years has been to bring the UK closer into alignment with other countries in terms of health care spending relative to GDP

- Currently however there is a freeze in spending. It has been projected by the King's Fund that if the current freezing continues, then the current proportion of 8% GDP spending for the NHS will go down to 6% by 2021/22.

Saving measures and their impact:

- The main measure used to address the funding gap has been to hold pay for staff, as well as to fulfil savings plans outlined through various so-called QUIPP actions[1] and disease management.

[1] QIPP actions= Quality, innovation, productivity and prevention, a programme for efficiency savings:

- Savings impact: quality has "held up" for the time being, though it looks as if some targets will be reached more slowly.

- Source of savings: these are mainly trusts/ hospital providers, though how savings are, and will be, achieved is not always entirely clear and/or transparent.[2]

Fundraising options and managing demand:

- These include: increasing charges/ creating new charges; general taxation; hypothecated tax.

Rationing:

- Rationing has always existed in various forms such as by denial/ deterrence/ delay/ deflection/ dilution.[3]

- Now, however, likely that rationing will happen on a larger scale.

In conclusion, the main question is how transparency of making these decisions is achieved – it is not always clear how CCGs are proceeding and on what evidence base.

Presentation 2: Funding pressures in the NHS: an ethical response

The presentation outlined the position of the NHS Confederation in the face of current funding pressures, expressing concern about the future of the NHS and whether the level of care can be upheld. The latest member survey produced by the NHS Confederation in support of the "2015 challenge" underlines these challenges.[4]

Survey results:

- 51% of respondents (senior leaders in the NHS) agree the service "needs to make large scale changes to the way it currently operates and provides services in order to maintain current levels of care", while 45% of resondents believe that

---

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213823/dh_117794.pdf

2 It was mentioned that background questions considered by the King's Fund and Nuffield Trust continue to be how much should be spent in total; and there are disagreements on the calculation of funding gap and demand.

3 Klein & Maybin (2012). *Thinking about rationing*. The King's Fund. http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Thinking-about-rationing-the-kings-fund-may-2012.pdf

4 http://www.nhsconfed.org/health-topics/2015-challenge

even if the NHS makes large scale changes, “this alone will not ensure it can maintain current levels of care”.

- A high number of respondents believe that there will be serious consequences in terms of service provision and ability to maintain high standards of care if service change is not achieved and the NHS budget remains flat in real terms.

- The consequences most frequently identified by NHS Confederation members include the risk of financial failure of service providers, reduced access to care for patients, reduced numbers of front-line staff, and reductions in quality of care.

- Measures to maintain quality identified by respondents centred on increasing prevention and action on staff costs, while fewer people suggested rationing or more user charges.

Ethical response: the ‘Decisions of Value’ project

- The NHS Confederation is working on this project with the Academy of Medical Royal Colleges to support more effective decision-making when there are both quality and financial implications. The work has three underlying principles (sector-led support, collaborative working and continual improvement) and has involved engagement across three levels: local (site visits and interviews); national (survey of clinical and managerial staff); and expert groups. Identified factors for improvement are:

    - “Relationships of value” - between quality/finance/service delivery as well as clinicians/managers/patients. This will imply stronger clinical and financial rapport; and greater patient involvement;
    - Fostering of “behaviours” and “environments of value” such as information-driven decisions and better peer support networks.

Presentation 3: User charges in healthcare – An alternative to implicit rationing

This presentation started from the assumption that, although the public and doctors in surveys always disapprove of introducing more user charges in healthcare, this should be seen as a result of the framing effect – we should not ask ‘do you want to pay for a service you could also have for free?’, but rather emphasise the transparency and benefits in terms of freedom of choice in this model, in particular as an alternative to implicit rationing.

Scope for and types of user charges:

- There is clearly scope for greater use of charges in the UK: direct charges are underused in comparison to other developed countries – even in the Nordic

countries, where around 20% of total healthcare spending comes from direct charges.

- There are different ways in which user charges can be applied, both in primary care and in inpatient care, and these are combined differently in different countries. There are none in the UK except for prescription charges.

Potential risks, harms and benefits in co-payment systems:

- Benefits of co-payment systems include:
    - more cost-effectiveness
    - less wastage
    - increasing transparency
    - "demystification".

- Risks and harms include:
    - disproportionate impact on low-income earners and people with long-term conditions; and
    - people not seeking care, with the self-defeating results of worse health outcomes and higher costs longterm.

- However, these potential harms depend on the parameters and specifics used If potential complications can be managed, there is "no harm in aligning incentives of patients and providers".

Comments by Respondents

Value-ladenness of terms

- "Prioritisation" or "rationalisation" and their connotations.

Quality assessment

- A useful approach to quality assessment is Maxwell's 'multimodal approach' (which distinguishes access to services/ relevance to need (for the whole community)/ effectiveness (for individual patients)/ equity (fairness)/ social acceptability/efficiency and economy).[5] Different professions will highlight different factors in this assessment, e.g. medics might prioritise effectiveness.

[5] Maxwell RJ (1984) Quality assessment in health. *British Medical Journal* **288**:1470-2: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1441041/pdf/bmjcred00500-0072.pdf

Scope of issues/role of NCOB

- If NCOB were to approach this issue, they could focus on making these choices and overall strategic investment in the NHS more transparent.

- Rationing should be considered in the wider sense: not just for what drugs can be afforded, but also what happens when staff and access to care are rationed.

- Are we currently making 'rational' decisions rather than following a legacy of historic decisions and general custom (for example in the focus on spending in emergency/ end of life care vs prevention)? Does the NHS take a holistic approach?

- It is beyond question that there are many ethical issues involved, but framing a particular question for a potential NCoB WP would be crucial, with the potentially remaining worry that the issues are too broad to tackle. There are two general possibilities:

    - "Broad systematic justice questions": exploring approaches such as accountability for reasonableness, or the 'user-pay' principle, or something else?

    - "Penetration of process": once decided, is this framework consistently applied? Council could consider the analysis of how the values chosen could better penetrate the NHS, for example across the various regions in the UK, or in terms of the relation between allocation and care. A particular 'penetration problem' arises at the interface of health and social care where different cultures (driven by evidence vs driven by need) to be integrated.

General discussion:

- Current developments in the NHS and the wider political and economic context are clearly reflected in the presentations, focussing on financial pressure and austerity politics, while there also seems widespread insecurity of diagnosis, effects and potential counter-measures. There is a move to engage the public and patients more directly to save costs, in direct ways such as through the introduction of user charges, and indirectly through prevention (only mentioned in passing). This again is reflected in discussions both on the **governance, organisation and management** of healthcare, and reflections on the source of problems such as:

- issues of ‘standardisation politics’ in the NHS, such as stark regional differences in quality assessment and allocation, or preference for spending in some areas (such as the focus on end-of-life-care contrasting with priority given to children’s mental health);

- the “unwieldiness” of the NHS– a reluctance or inflexibility in taking up technology, or rather an effect deriving from inadequate or insufficiently worked-out forms of seeking a more cost-effective, more liberal health care system; and

- transparency in decision-making..[6]

- These turn on further **partly ethical,** but also **partly epistemological, economic and cultural issues**, such as:

    - the culture clash between choosing on evidence base vs. choosing according to need if there is to be increasing integration of health and social care; and
    - the clash between macro-level utilitarian ethics and micro-level care ethics of GPs.

- A number of **long-standing debates** are relevant, such as

    - How much should we spend on health, i.e. how important is health and healthcare, both absolutely and relative to other investments?
    - Is there a right to health, and what “amount” of health should we be aiming for?
    - Intergenerational justice in healthcare spending;
    - “lifestyle justice”;
    - What is the collective good in healthcare, and how can it best be achieved?

Are there new issues in rationing?

The debate on rationing in the NHS might have a new quality in that it is becoming clearer that “we are rationing quality” – there is a new explicitness of this approach, new narratives, and perhaps also a shift in what people are prepared to tolerate.

[6] Transparency of healthcare spending was considered one of the advantages of increasing and perhaps creating new user charges.

The role of the Council?

Although these developments tie in with very important philosophical and ethical debates, there seems to be an "exceptional broadness" to the issues, while the specific expertise the NCoB could bring to it is not well defined.[7] The questions to be addressed would have to be narrowed down substantially, starting for example with the following consideration: given that rationing is unavoidable, what would be the most ethical way of proceeding?

[7] A number of other organisations were mentioned as better placed to investigate specific aspects of the topic, on economic and organisational aspects e.g. the King's Fund, and on broader ethical questions e.g. the current revision of NICE's "Social Value Judgements: Principles for the Development of NICE guidance": see http://www.nice.org.uk/aboutnice/howwework/socialvaluejudgements/socialvaluejudgements.jsp