

Patients and consumers

R Downie¹



Successive governments of the UK have strongly supported two policies: an NHS free at the point of delivery, and the encouragement of consumer choice. It was natural for governments to think that amalgamating the policies would increase patient satisfaction, improve efficiency and save money. There are many reasons why this has not been well-received by patients and doctors and has not saved money, but the underlying problem is that there

is a conceptual misfit between healthcare as public policy and as individual responsibility. Patients in the NHS cannot become consumers and doctors cannot become suppliers of goods and services.

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Introduction

Consumerism has been a growth movement since the Industrial Revolution and it rapidly developed in the 20th century. The movement emphasises that the free choice of consumers should affect the choice of manufacturers on what is produced and by that means orient the economic organisation of society.¹ A policy of offering healthcare free at the point of need was outlined in the Beveridge Report of 1942 and adopted by the British Government as the NHS in 1946. The consumerist movement and the NHS have both become very popular with the public. It is therefore not surprising that successive governments from the 1980s have made attempts to marry the two. The aim is to improve the NHS by introducing consumer choice while keeping the service free at the point of delivery. The hope is that the introduction of consumer choice will both increase patient/service-user satisfaction and improve efficiency. Although the idea of this marriage derives from right-wing free market assumptions, governments of a more left-wing persuasion have made no serious effort to reverse the trend to a consumer-based NHS.

The general public however remain suspicious of what is seen as the privatisation of a public service, the healthcare professions remain critical or indeed hostile to consumerism in healthcare and the costs continue to rise. There are many reasons for these adverse effects, but from the philosophical point of view, the fundamental reason is a conceptual misfit between a publicly funded service free at the point of delivery and the free market assumptions of consumer choice. I shall consider three areas of conceptual misfit: (i) the incompatibility of patient choice and consumer choice, (ii) confusions over the term 'best interests', and (iii) the

centrality of equity in a publicly funded service contrasted with its absence in a consumerist free market.

Patient choice and consumer choice

The everyday conception of choice and consent to medical treatment

The word 'choice' is familiar in ordinary language where it overlaps and in some contexts is interchangeable with words such as 'decide' or 'pick'. For example, a conjuror might equally say, 'Choose a card' or 'Pick a card', and looking at a holiday brochure we choose or decide where to go. Nevertheless, it is possible, without too much artificial stipulation, to build up a model of choice as the term is used in ordinary language. First, a choice must be free from external constraints or pressures. This bald statement requires qualification. Friends urge us, advertisers persuade us, and many other constraints affect us, so that in a given context it might be debated how free a choice really was. Nevertheless it is not really contentious that a genuine choice requires some degree of freedom. Second, there must be at least a few alternatives, as in a chocolate box. Third, there must be a minimum of information: the diagram on the chocolate box lid might be adequate for that choice but the choice of a car would require much more information. Without the appropriate amount of information we are picking rather than choosing. Finally, we must take personal responsibility for the choice. If we don't like what we have chosen our friends say, 'It was your choice'. These conditions of choice in ordinary language – freedom, alternatives, information, responsibility – helpfully spell out the acronym FAIR, and I shall use the acronym as a convenient shorthand way to refer to the model of choice we accept in everyday life.

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The ordinary conception of choice – FAIR – enters medical practice via the term more commonly used in healthcare – consent. Consent to medical treatment is now a foundation principle of medical ethics. Briefly, it has two main roots: the law of battery, that it is a legal offence for one person to touch another without consent, and the ethical idea that we all have a right of self-determination with respect to our bodies. It should be noted here that ‘consent’ as used in medical law and ethics differs from the way the word is used in everyday speech. If you ask me to meet you for a drink after work and I say ‘Ok’, I have in the ordinary context consented to go for a drink. You are not required to spell out whether we will be drinking beer or coffee. In other words, ‘consent’ in everyday contexts is just a matter of freely agreeing to what is proposed: it meets the first condition of the ordinary sense of ‘choice’. But in the medical context the doctor must also suggest possible alternatives and provide adequate information: conditions 2 and 3 of ‘FAIR’. The fourth condition – responsibility – is shared: the doctor takes responsibility for the alternatives, the information and the action plan, and the patient takes responsibility for choosing an offered action plan. In other words, the preferred medical model for consent simply adopts FAIR with the extra proviso that the responsibility for the final choice is shared.²

Consumer choice, competition and patient choice

But consumer choice has conditions additional to those stipulated in FAIR, and if consumer choice is to enter the NHS then these additional conditions must be present. These conditions are at variance with medical law and the traditions of medicine. The first of them is competition. From the time of Adam Smith, competition has been regarded as a necessary condition for a free market and therefore for consumer choice in that market. Consumerism requires competition of two sorts: between the consumers of goods and services and their suppliers; and among the suppliers of services. Successive governments from the 1980s have tried to introduce competition of both sorts to the NHS.

Consider first the attempt to introduce competition between consumers (patients, or ‘service users’) and suppliers or providers (GPs or hospitals). To create competition in this context, league tables have been published, showing such results as waiting times, operation success rates, and so on. The measurements involved are often disputed but, even if we leave that aside, league tables do not help the vast majority of patients. For example, the elderly who make up the majority of patients may not have the skills or energy to investigate league tables, but must rely on advice from their GP; those who require urgent care via emergency services have to use the nearest service; and in general if you are ill you lack the energy to get involved in competition. Choice overload can cause the debilitating effects of bewilderment and high levels of stress and anxiety. Genuine competition between patients and providers is an illusion.³

Turning now to competition between different providers we encounter another kind of problem. The foot soldiers of the NHS are the doctors and nurses who serve the patients.

But the process of their education and tradition is quite contrary to the ethos of competition. From the start of medical education, students are taught together and share a curriculum which is largely similar for all students, and even extra-curricular activities reinforce the ethos by informal student societies, such as ‘year clubs’. Such factors play a role in inculcating a sense of loyalty even in the earliest years. This loyalty is directed partly towards the institution and its members, but also towards medicine itself. In later years, ways of relating to patients and other health workers, even in other institutions, becomes part of medical professionalism. The professional ethic of medicine is quite inimical to the individualistic ethic of commercial competition.

It might be objected to this point that whereas medical professionalism may be incompatible with institutional competition it is in fact the managers and chief executives of hospitals who will manage the competition. While this is true, this truth creates another problem for competition in the NHS. The problem is that managerial attempts to encourage a competitive spirit among doctors, say by stressing the importance of meeting targets, can create disharmony between management and medical staff. The medical ethos is concerned with patient care, rather than targets.

This suggests that since consumer choice requires competition to be added to the sense of choice (FAIR), which underlies joint decision-making in medicine, then consumer choice sits in tension with medical practice. Patients are able to decide whether they prefer Tesco or Waitrose but the evaluation of league tables is much harder and sometimes impossible. Moreover, the traditional ethos of medical education and its resultant professionalism is quite inimical to that of competition. But competition is not the only problem that arises for consumer choice in the NHS. Two further problems concern the alternatives for choice and the locus of responsibility.

Alternatives and responsibility in patient choice and consumer choice

In FAIR the alternatives are displayed, for example on the lid of the chocolate box, and in the development of this in a medical situation the treatment alternatives are outlined by the doctor. In other words, the number of possible choices is limited. But the choices of consumerism are not constrained in this way. If one shop does not have the product another might or the consumer can go online and have the commodities of the world available. There are no limits to the number of alternatives and it is the consumer who is the dominant figure. Current political policy is to develop a version of this enlarged idea of competitive consumer choice within the NHS. The hope is that if one hospital cannot offer the treatment or care regime then perhaps another can. If medical research suggests that a treatment is not adequately tested or cost-effective then the consumer ethos encourages patients to write to the newspapers or their MP and it is likely to be made available. Indeed, there is general protest, sometimes extending to outrage, if a cancer treatment is judged not to be cost-effective and therefore not provided

on the NHS. The underlying problem here is that of equity for the NHS, which I shall discuss in a separate section. But in addition to raising problems of equity, the extensive alternatives of consumer choice also raise problems about the locus of responsibility in a medical situation.

In FAIR and its extension to joint decision-making, the locus of responsibility is clear: the doctor has responsibility for offering the choices and carrying out the one chosen by the patient. But on a consumer choice model the patient might say: 'I have read about a certain treatment on the internet and that is the one I want.' In other words, the patient can widen the range of choices. Doctors are not infallible and perhaps after consideration the doctor might agree with the patient's preference. But the doctor might judge that the patient's choice is not cost-effective or not tested, and refuse to grant it. Where does the responsibility for choice lie? To illustrate the problem here let us take an example.

Suppose I wish to purchase a computer and explain to the retailer that it is for word processing, emails and other simple tasks. The shop assistant suggests one or two models, but my eye alights on one with a spectacular screensaver, and I say that I want that one. The assistant patiently explains that that model is complex and is really for scientific purposes. I insist and put my money down. The shop assistant having provided adequate information has no duty to refuse the sale. But if after a week of despair I return it to the shop the seller has no duty to take it back. The point is that having been given adequate information, the purchaser carries the responsibility for the choice. But this situation does not apply in medicine. In law it is the doctor who carries the responsibility. In other words, the locus of responsibility in the two contexts of consumerism and medical professionalism are incompatible.⁴

Best interests

It is often said that one merit of a consumer-based system is that it enables patients to achieve their own best interests. The assumption here is that patients know their own best interests whereas in the NHS, doctors decide what is in the patient's best interests. In support of this assumption it can be pointed out that in the FAIR model of choice, as it applies to medical decision-making, it is the doctor who offers the treatment choices in what the doctor decides is the patient's best interests. But there is a confusion here that arises from an ambiguity in the concept of 'interest', an ambiguity between a psychological and a normative sense. 'Best interests' in the psychological sense refers to choices arising from what people actually want to have. 'Autonomous choice' is usually interpreted in this way as a choice expressing what the patient wants. But 'best interests' in the normative sense refers to what a patient ought to have, whether or not he in fact wants the offered treatment. For example, it might be in a person's best interests in the normative sense to take some exercise or cut down on sugar but he might not want to. As we say to the relative reluctant to accept the treatment, 'It's for your own good'.

Now, in the framework or value-base of consumerism the psychological and the normative senses will run together, for a person's best interest in such a framework or value-base is simply the satisfaction of his wants. But in the framework or value-base of medicine the psychological and normative sense of 'best interests' are quite separate, and the doctor's professional duty is to offer treatments from the normative interpretation of 'best interests'. This normative view will have two components: a duty to promote the health of patients where possible, and an awareness of the safety and cost-effectiveness of treatments. Of course the patient is entitled in law to refuse the doctor's offer of choices based on this normative view of best interests, even in cases where life-prolonging treatment is involved.⁵ But the central point is that the psychological sense of 'best interests' expresses the value base of consumerism while the normative sense expresses that of medical professionalism.⁶

Equity

An important principle that ought to guide but not wholly determine public policy is utility, or the maximising of benefit for the majority of a population. This general principle turns into specific economic tools such as cost/benefit analysis or quality-adjusted life years and is presented to the public as 'value for money'. But it is obvious that this ought not to be the only guiding principle. For example, suppose a doctor is faced with a patient who might benefit from an expensive drug. In terms of maximising benefit to the community at large it might be better to ignore the needs of patients with that kind of condition and spend the resources on those whose need is less severe but who might benefit more. But this policy seems wrong in that it ignores the rights of individuals to equal consideration. No one ought to be regarded simply as expendable for the sake of the good of others.

This notion of 'equal consideration', however, needs more examination. In some contexts the demand for equal consideration is simply a demand for consistency of treatment between one person and another. In other words, it is a demand that people be treated in accordance with a rule which can be formulated. But the demand for consistency seems to clash with the more personalised side to casework in the NHS; general rules conflict with the uniqueness of individual situations. On the other hand, patients are keen to demand consistency and criticise anything which smacks of a 'postcode lottery'. Consistency seems to be a necessary condition for the distribution of medical or social benefits to patient groups if such distribution is to be seen as fair. But consistency is certainly not sufficient for fairness. After all, a principle such as 'Never spend time with anyone who is disabled or alcoholic' could be applied consistently. To get nearer the moral principle of equal consideration we need some way of ruling out such possibilities.

It is tempting to try to do this by saying that what is required is not consistency but an actual equality of treatment. But this is not satisfactory either. As pointed out above, clinicians stress that some people need much more help than others

within patient groups, and no one thinks it reasonable to spend the same amount of time and money whatever the problem. What is required is that all differences of treatment be based on a criterion which will group like cases together, and distinguish unlike cases, for morally appropriate reasons. This principle of justified differences in treatment is usually called a principle of equity. Equity is not the same as equality, since it requires not only that like cases should be treated equally but also that unlike cases should be treated unequally. Equity presupposes a criterion for justifiable differences in the way people are treated. In the context of illness or disease this criterion will be need (although in other contexts criteria such as merit, or ability to benefit, might be relevant).⁷

But this analysis highlights the problem of what is to be meant by 'need', a term which is easy to pass over since it is so familiar in this kind of discussion. A 'need' arises from a desire or an aim to reach a certain goal; that which is needed is instrumental for attaining the goal. But what is the goal in healthcare? Some economists propose a very wide goal, and define need as a 'capacity to benefit'.⁸ According to this definition, people 'need' from health and social services anything that might benefit their health and wellbeing. But that would include good housing, lack of deprivation, rewarding employment, and so on. Patient groups might well say 'Yes, that is what we do need!' But there is the problem of resources and their allocation not only for health groups, but also for other areas requiring spending from the public purse, such as education, defence and the arts. It is therefore arguable that 'capacity to benefit' is too broad a definition of need. The American ethicists, Beauchamp and Childress, suggest a narrower definition of 'need' as 'that without which one will be fundamentally harmed'.⁹ This provides a minimum level for the relief of needs. But it must be remembered that the USA takes a much narrower view of what the state should provide by way of health and welfare benefits than would be acceptable in the UK. It might be preferable for those in healthcare to drop the idea of a 'needs assessment' and to concentrate on specific goals: the alleviation of pain and discomfort, the restoration or maintenance of function and the prolongation of life of a human quality.¹⁰ But even with specific goals, controversy will remain. In the context of scarce resources we shall probably never be free of disputes about both government policies and 'postcode lotteries'. The implication of all this is that there is really no escape from some form of rationing, whatever politicians may say, or whatever is their preferred term – 'prioritising' or the like – or preferred method of rationing.

But however imperfect these attempts at prioritising may be, they have the merit that they attempt to incorporate some conception of equity in the distribution of a public good such as healthcare. On the other hand, in the pure form of a free market consumerist system of healthcare, equity and utility do not feature at all. Treatment alternatives are the choice

and responsibility of the individual patient; the principles of utility and equity are simply not relevant because healthcare is a choice for the consumer rather than a public good. Basically you would get what you paid for. There would of course be legal principles covering such matters as safety and redress over negligence. But it would be up to patients – who are now healthcare consumers – to compare insurance companies and work out the package that best and least expensively implements their choices, and up to insurance companies to work out which packages are likely to be the most profitable for them. The principles of utility and equity are totally irrelevant to this kind of system, but are essential for the working of a publicly-funded system of healthcare. No doubt a case can be made for each sort of system but the attempt to combine systems with incompatible logical structures leads to confusion and inconsistency.

Conclusion

I have argued that joint decision-making, currently the preferred model in the NHS, represents a development of the everyday conception of choice which I encapsulated in the acronym FAIR. The consumerist model of choice however adds elements not present in either FAIR or joint decision-making: competition, a wider range of alternatives and a change in the locus of responsibility. Moreover, a consumerist view of best interests – 'my interests are to get what I want' – may conflict with medical values: 'the patient's best interests are expressed by the attainable medical good'. Underlying all these conflicts is the problem that a consumerist free market system does not require the principles of equity and utility that are essential in a publicly funded system such as the NHS. Of course a consumerist system has merits – such as stressing individual responsibility for healthcare – and it may therefore be preferred by some societies. But the attempt to combine a consumerist system with one which is publicly funded will give rise to tensions and contradictions, rather like the attempt to combine incongruent triangles. ①

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