The rapid increase of the number of people over 85 may be expected to lead to increased demand for long term care. Part of this care will be provided by informal arrangements in which the elderly play an important role as providers, part will be paid for by the consumers themselves or by private insurance, and part by collective funding for institutionalised care. In particular, this last form of care requires government involvement as previously stated. There is no way in which the private insurance market can be expected to provide long-term care insurance for all groups in need of such entitlements.

In the last chapter of his revised book *The New Politics of the NHS*, Rudolf Klein argues that the British health care system is at a cross-roads; it has to choose between the 'garage-model' versus the existing 'NHS-model'.[15] This dichotomy in options may be less sharp. Perceptions about the elderly are changing, as well as perceptions of the elderly about themselves; so are their actual positions. Governments will have to reassess their policies, leaving more room for differentiation.

REFERENCES

[1] Binstock RH. Health care policies and older Americans. Paper for presentation at the 1995 Meeting of the American Political Science Association. August 31–September 3, 1995, Chicago.

[2] Rhodeback LA. Competing problems, Budget constraints, and claims for generational equity. Paper presented at the 1995 Meeting of the American Political Science Association. August 31–September 3, 1995.

[3] Marmor TR, Cook FL. American politics and social security: The old versus the young. In: Social Security in the 21st Century. Schultz and Kingman, eds. Oxford University Press (in press).

[4] OECD 1992. The Reform of Health Care. A Comparative Analysis of Seven OECD Countries. Paris: Organisation for Economic Co-operation and Development.

[5] OECD 1995. The Reform of Health Care Systems. A Review of Seventeen OECD Countries. Paris: Organisation for Economic Co-operation and Development.

[6] Ageing populations. The social policy implications. Paris: Organisation for Economic Co-operation and Development.

[7] Averting the Old Age Crisis. Policies to protect the old and to promote growth. Summary. Research Report. Washington DC: World Bank, 1994.

[8] Steckenrider JS. Ethics of rationing health care: From an aging perspective. Paper prepared for the 1995 Meeting of the American Political Science Association. August 31–September 3, 1995, Chicago.

[9] Zweifel P, Felder S, Meier M. Ageing of population and health care expenditure: a red herring? Paper presented at the Second International Research Seminar on Issues of Social Security. Foundation for International Studies on Social Security. Sigtuna, Sweden, June 17–20, 1995.

[10] Wiener JM, Illston LH. How to share the burden. Long-term care reform in the 1990s. The Brookings Review, Spring 1994 Vol 12, no 2; 17–21.

[11] Wasem J. Private health insurance markets. In: Report of the four country conference on health reforms and health policies in the United States, Canada, Germany and The Netherlands. Amsterdam, February 23–25, 1995.

[12] Massie CZ. Toward a new theory of aging to inform long-term care policy and planning. Paper prepared for presentation at the 1995 Meeting of the American Political Science Association. K. G. H. Okma August 31–September 3, 1995, Chicago.

[13] Lipovenko D. Care of the elderly falling to grandchildren. *Globe and Mail*, Oct 23, 1995.

[14] Svanborg A. Postponement of aging, a social issue. Lecture at the Second international research seminar on issues of social security. Foundation for International Studies on Social Security. Sigtuna, Sweden, June 1–20, 1995.

Leibfritz W, Roseveare D. Aging populations and government budgets. The OECD Observer, Dec 1995/Jan 1996, no 197: 33–37.

Rochon M. Impact of the evolution of health expectancy on future public health care costs. Paper presented at the Second international research seminar on issues of social security. Foundation for International Studies on Social Security. Sigtuna, Sweden, June 17–20, 1995.

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ETHICAL AND ECONOMIC DILEMMAS IN THE NHS*

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An ethical dilemma for government is to decide what proportion of public expenditure should be spent on health care. In the United Kingdom it is just over 7% of gross domestic product (GDP) and ranks seventeenth amongst OECD countries with only Spain, Denmark, Portugal and Greece spending less. The UK spends approximately £750 per head whereas Germany, France and the USA spend between £1,500 to £2,000. Ideally the allocation of finance requires expenditure to be linked to measures of health outcome. Measuring health outcomes is difficult and complex, and a decision to allocate resources is often influenced by political factors which may have little to do with anticipated health benefits. The simplest form of linkage is between life expectancy and expenditure. For example, some Central African States, where life expectancy is 39 years, spend $60 per capita per annum on health; in the USA, where life expectancy is 78 years, $60,000 is spent. Life expectancy of course depends on many socio-economic factors related to direct expenditure on health care. In developed countries much of the huge cost of health goes towards improvements in the quality of life and has relatively little impact on life expectancy, compared with that of the direct care in poorer countries. While there is no immediate panacea to the problem of resource allocation at a national level, the problem is all too real however at the levels of local health boards and trusts where real rationing decisions have to be made. This leads to significant ethical and economic conflicts for doctors and managers.

RATIONING

There is no generally accepted, nationally applicable, ethical principle which can be used to resolve conflicting claims on limited resources. As Klein has observed, the process of rationing begins from the moment a patient enters a general practitioner's surgery. This may take the form of rationing by deference, rationing by delay, or rationing by dilution, and even rationing by discharge.[1] All of these methods of rationing within the system are less than explicit. Furthermore the basis of rationing decisions taken by Health Authorities and purchasing teams, when deciding on resource allocations are also often less than explicit. None the less, these bodies are beginning to make explicit rationing decisions and it is not uncommon for Health Authorities to have exclusion lists of treatments that will not be purchased, for example removal of a tattoo.

Some local Trusts have attempted to make this process more rational and explicit by involving management and the doctors in decisions on resource allocation at the earliest possible opportunity. In the Edinburgh Western General Hospital Trust for example, budgetary authority is devolved to Clinical Directors who have responsibilities for both income and expenditure, and increasingly, for

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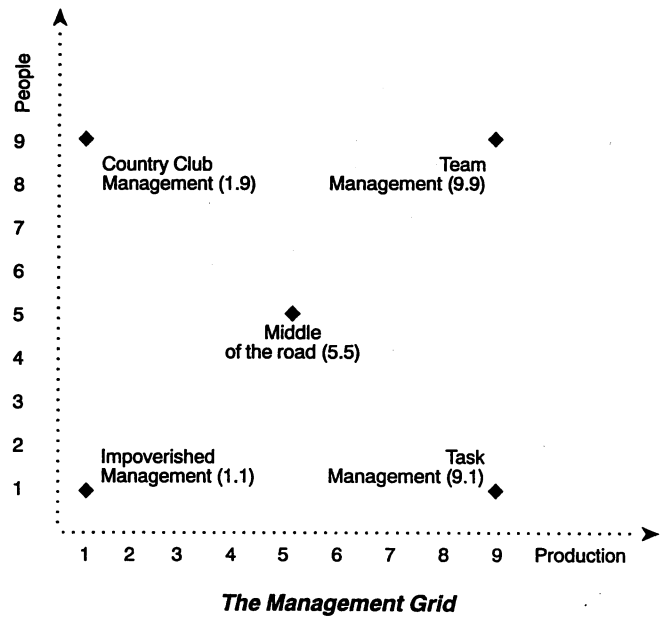

FIGURE 1

direct negotiations with purchasers. Previously contract negotiations were conducted by senior management and often lacked the medical, ethical and technical dimensions which may be introduced by clinicians.

Involving doctors in contracting however poses an ethical dilemma. Implicit rationing is accepted only because the general public trust doctors to act as their advocates and to represent their interest. The strength of this trust varies from one country to another reflecting differences in cultural attitudes and financial provisions. Thus it is stronger in the UK than in the USA. Patients are uncomfortable with the idea that their doctor must balance their needs against the needs of others, and 'if patients truly knew the extent of developing conflicts of interest built into existing financial and organisational arrangements, their trust would be much diminished.[1,2] Having regard to the ethical conflicts involved in these concerns, clearly health professionals need to be involved in decisions on resource allocations and rationing, providing the price of this is not an erosion of trust in professional and clinical judgement.

MANAGEMENT AND ETHICS

Management behaviour and style also have ethical implications. The Blake and Mouton Managerial Grid is one of the models presented to raw recruits to business school (see Fig 1). In this, management is classified in two dimensions. One, on the horizontal axis, represents concern for the task, and the other, vertical axis, represents concern for people. A manager scoring 9.1 on this grid is highly task-oriented and regards human resources as a commodity to be sacrificed for achievement of the task. Those at the other end of the scale scoring 1.9 are described as 'country club managers' with whom good fellowship prevails; the task is incidental and avoidance of conflict is the prevailing organisational culture. The ideal should be the manager who scores 9.9 and who recognises that

achievement of the task and long term success of his organisation depends not only on being focussed on the task but also on ensuring that his team is trained, well motivated and supported. Most organisations will probably fall somewhere in the middle of the grid. The challenge for managers is to balance the requirements of the task with concern for the work force; in a well-run organisation, these requirements should converge.

In respect of other ethical problems which present difficulties for Trust Boards a study was carried out in Manchester which showed that the determination of treatment priorities is only one of a number of ethical issues which regularly arise (Table 1). This may be because most of the debate on rationing occurs below Board level.[3] Alternatively it may be because rationing and resource allocation is determined at Health Board level which leaves little room for altering priorities at lower levels. Suggestions to guide ethical decision-making have been promoted by the *British Journal of Nursing*[4] (Table 2).

TABLE 1

Ethical issues that confront Board members

Conflict of interest and personal gain
Determining priorities in treatment
Discipline
Interpreting the rules
Accountability to the public
Fairness to staff

TABLE 2

Seven ethical questions for decisions

Is it fair?
Am I being honest?
Does it hurt anyone?
Can I live with myself?
Would I publish my decision?
What if everyone did it?
Source: Hall 1992.

CONFIDENTIALITY AND TRUSTS

Most Trusts have a policy on openness and debate has focussed on whether or not Board meetings should be open to the general public. Some Trusts already hold open meetings. The presentation of Trust business which is concerned with individual or departmental performance might be constrained by the presence of external observers. Most Trusts allowing public attendance operate a system of passive observance which makes public participation meaningless. A suitable compromise might be the holding of meetings between staff and the public to enable those in charge to be questioned on their stewardship.

Issues of confidentiality arise with respect to complaints and to 'whistleblowing'. Trust complaints systems tend to be too defensive and need to be more open with a willingness to acknowledge problems. Most studies of whistleblowers show that the act of going public involves some personal risk. In an organisation with a strong ethical code of conduct and good lines of communication the need

to 'whistleblow' should not arise. The Whistleblowers Protection Act 1989 in the USA allows disclosure of information 'which the employee reasonably believes evidences a violation of any law, rule or regulation, or gross mismanagement of funds, an abuse of authority or a substantial and specific danger to public health or safety'.

THE MARKET

The internal health market poses a number of dilemmas and it is unclear to what degree the Government intended it to mirror the economic behaviour of free markets described by classical economic theory. The government perceived great benefits would accrue from the introduction of market forces into health care, and particularly by its purported ability to enhance patient choice and to improve efficiency and effectiveness.

The foundation of the reforms was the purchaser-provider split but most now accept that a balance is required between free competition and the control of change through strategic planning.

The most difficult ethical problem facing Trusts relates to the two-tier market, especially when fund-holding by practitioners is involved. Managers do not wish to refuse a source of income but it is morally indefensible to offer explicit differential access to a service which is national and funded by the tax-payer. There is tacit acceptance that an organisation as large as the NHS cannot have all of its elements moving at the same pace and is, by definition, 'multi-tiered'. None the less accepting an unavoidable lack of uniformity is not the same as creating financial incentives which promote inequity of access and therefore a two-tier service. Hospital clinical and management teams have an important responsibility in this respect since some services will have to be supported with only part of the funding being in place until all purchasers have 'caught up' in the system.

COMPETITION AND CONTRACTING

There remains uncertainty and tension as to whether the NHS should be considered a market or a command hierarchy. While there are clearly market-like forces at work in the competition between providers, the service has social aims and a global spending limit. The tension is most acute for providers who believe they are competing in a free market yet are subject to a stream of commands concerning issues which affect their competitive position: thus in Lothian two large acute Trusts, have to act in tandem in order to meet the aspirations of the Lothian Acute Services Strategy.

Certain core elements (Table 3) underlie effective management of the NHS market.[5] Best has suggested that 'unless a theory and practice of market management appropriate to the NHS are developed, the NHS may suffer the worst of both worlds; stifling bureaucracy at the top combined with parochial self-interest and purchaser-provider confrontation locally.'[6]

As already pointed out there are obvious ethical dilemmas connected with the position of doctors involved in management who must make financial decisions which affect the care of individual patients. The 'dream scenario' of decisions being made on the basis of hard facts, the driving force of the hospital being the clinical team, allowing decisions to have a clinical perspective has been described and contrasted with the 'nightmare scenario' where clinical managers are in place

on paper only, clinicians receive the blame for overspending but have no real authority and little real support.[7]

TABLE 3

Elements in the management of the NHS

Protection of NHS principles
Open information
Control of the labour force
Disputes and arbitration
Protection of the unfashionable
Strategic overview
Control of capital
Regulation of mergers and takeovers
Dealing with closures

SUMMARY

This brief review has considered a number of significant issues which are of importance to both doctors and managers. Rationing and the setting of priorities is becoming increasingly explicit as a natural result of the contracting process and the production of strategic plans by Health Boards. The public is also much better informed and individuals clearly regard themselves as stakeholders in this process. While some Health Boards have published lists of treatments to be excluded, consensus is still distant; in the future, purchasing intentions will be more firmly linked to outcome indicators. Most health professionals would welcome the introduction of explicit rationing criteria, but their development must reflect adequate consultation with, and contributions from, the professions. The involvement of health professionals in the decision-making process may alter their relationship with patients and great care must be taken to ensure that there is not a breakdown of trust. 'Good professional management requires the full participation of consumers and purchasers alike. Above all, government and managers must recognise the value of professional judgement and involvement by professionals in the management of the health care system'.[8]

REFERENCES

[1] Klein R. Rationing in action—dimensions of rationing: who should do what? *Br Med J* 1993; **307:** 309–11.

[2] Mechanic D. Dilemmas in rationing healthcare services: the case for implicit rationing. *Br Med J* 1995; **310:** 1655–9.

[3] Sheaff R., West M. Back to basics. *Health Serv J* 1994; 24 February: 26–9.

[4] Fox J. Ethics: an emerging management issue. *Br J Nursing* 1994; **3:** 1179–81.

[5] Ham C, Maynard A. Managing the NHS market. *Br Med J* 1994; **308:** 845–7.

[6] Best G, Matthew D, Knowles D. Managing the new NHS: breathing new life into the NHS reforms. *Br Med J* 1994; **308:** 842–5.

[7] Simpson J. Doctors in management—dream or nightmare? *Proc R Coll Physicians Edinb* 1994; **24:** 197–202.

[8] Macara AW. Reforming the NHS Reforms. *Br Med J* 1994; **308:** 848–9.