The ethical implications of the use of market-type mechanisms in the delivery of NHS care

A discussion paper from the BMA’s Medical Ethics Committee
Summary

Successive recent governments have increasingly looked to commercial models to reform the NHS in England. These changes have been driven by the search for efficiency savings and the desire to improve patient choice and satisfaction. Although markets are highly efficient at allocating resources in some circumstances, the extent to which a supply-side market in publicly-funded health care can be effective according to the desired outcomes, remains, currently, unproven. Economic theory has identified that markets in health are prone to failure, many in ways that can be detrimental to patient interests.

Although there has been considerable research into the effectiveness of markets in the English NHS, discussion about the ethical and professional implications of a more commercially-oriented practice has been more muted. In this paper we identify a number of ethical concerns raised by these changes. In addition to poor evidence of effectiveness, there are well-founded questions about the impact of commercial models of delivery on medical professionalism and on trust in the doctor-patient relationship. Obvious examples of this have included the potentially detrimental effects of targets and incentives, as well as the proliferation of conflicts of interest in the new commissioning environment. Finally there is the question about the social desirability of the increasing commercialisation of public services, including health. By subjecting certain social goods, such as health care, to market forces there is a potential to change the nature of the goods themselves.

Background

The NHS in England has been subject to significant market-oriented reforms since the 1990s. Successive governments have looked to a variety of mechanisms drawn from market economics to bring about hoped-for improvements in efficiency, quality, flexibility and overall patient satisfaction. The Health and Social Care Act 2012 has both consolidated and further encouraged these reforms. Patient choice, competition between providers and the entry into the market of a range of private and third sector providers have all been promoted. In addition to structural reforms, tools more frequently associated with commercial enterprises, such as targets and financial or other incentives have proliferated. The growth of private providers has also resulted in more health professionals being employed directly by commercial organisations with as yet poorly-understood implications for professional practice.

Outside the UK, in many countries, the involvement of commercial organisations in the delivery of medical care is well-established, with some relying almost entirely on market provision. What is perhaps unique in the English experience is the scale and nature of the change in the way health care is provided. The NHS in England is in the process of moving from wholesale public provision, particularly in secondary care, where the kinds of ethical and professional concerns we discuss in this paper were largely muted, to one with increasing commercial involvement in delivery. To make things more complicated, primary care has always been delivered on contract to the NHS, as have other health services such as dentistry and optometry. Doctors and other health professionals working in these areas may understandably want to take advantage of the new environment. In addition, NHS consultants have always been able to undertake private work outside their NHS contract.

Despite the complexity of the picture, this paper explores some of the potential ethical implications of these market-oriented reforms. Recognising the specificity of the English experience it also draws on high-profile debates in the United States about the increased commercialisation of health care following the introduction of managed care. It looks at the ethical drivers for reform and the mechanisms put in place to achieve it. It critically appraises the effects of those reforms and explores the practical and ethical implications of their consequences, both intended and not. It also explores the impact of market mechanisms on medical professionalism, again drawing on earlier US debates. It concludes by asking, more speculatively, whether health goods and services are the kinds of thing that can be traded — or subjected to commercial-type exchange — without moral detriment.
Currently, with only a relatively few exceptions, NHS care is provided free at the point of need. There does not seem to be a political appetite to move toward a fee-for-service model. This paper therefore assumes a publicly-funded service that is largely free to users. The market mechanisms are restricted to the supply side. Any move towards private payment would take us into very different ethical terrain.

**BMA policy**

Since the introduction of internal markets in the NHS in the 1990s, the BMA has been critically involved in questioning the use of market models in the delivery of publicly-funded health care. The BMA is committed to a publicly-funded and publicly-provided NHS that is funded by taxation and free at the point of care. The BMA’s concerns with the introduction of market models have been manifold but have included:

- the possibility of markets to fragment care pathways and to destabilise, through possible economic failure, local health economies;
- the need for commercial organisations to maximise profitability will entail money being taken out of the health economy that could have been used for patient care;
- that commercial organisations will always experience conflicts between obligations to shareholders and obligations to promote the best interests of patients;
- the possibility that commercial organisations will cherry-pick the easier and more profitable areas of care, resulting in a ‘two-tier’ health service;
- the lack of obligation on commercial organisations to participate in education and training to the detriment of the medical workforce and patient care;
- that the much-trumpeted policy of ‘patient-choice’ failed to give patients the choices they most valued – and that patients were most likely to choose local access to good quality care from a known and trusted NHS provider;
- that the administrative and transaction costs of developing internal markets and competitive tendering take huge resources away from patient care.

Policy developed at the BMA’s Annual Representatives’ Meeting (ARM) in relation to marketization, and the changes introduced by the Health and Social Care Act is extensive. Two indicative policies are given below.

**(ARM 2014)**

That this Meeting is dismayed that private providers have won so many tenders for clinical services in the English NHS since the Health and Social Care Act came into force, and:

i) believes the market in healthcare has led to fragmentation and waste with adverse implications for patient safety, quality assurance and training;

ii) calls for the repeal of competitive tendering legislation;

iii) calls for a patient-focused healthcare system based on collaboration, cooperation, transparency and accountability.

**(ARM 2012)**

That this Meeting condemns the passing of the Health and Social Care Act and resolves that the BMA must:

i) highlight how the Act will lead to increasing NHS privatisation;

ii) continue to call for full publication of the NHS risk register;

iii) monitor and collate information about the effects of the Act on the NHS and the profession;

iv) co-ordinate the presentation to the public of the view of the medical profession on the Act;

v) provide guidance and support to doctors on mitigating damage to the NHS;

vi) continue to strive to find mechanisms to protect an NHS which is both sustainable and free at the point of delivery for all UK patients;

vii) make proposals to mitigate and reverse its damaging effects;

viii) campaign for repeal of the Health and Social Care Act.
Part one: market mechanisms in the NHS

Why have market mechanisms been deployed?
The reasons behind the progressive introduction of market mechanisms are manifold. One of the less-controversial is scarcity. Despite an early post-War consensus that there was a fixed sum of ill health, and once addressed by free public health provision, the NHS would shrink as illness was ‘mopped up’, demand still outstrips supply. (These views were not as naïve as they may sound. At the time, ill health was largely associated with readily curable diseases such as tuberculosis and poliomyelitis.) In ordinary economic circumstances, price regulates demand for scarce goods. Having made the political decision that access to health is morally too important to be restricted by one’s ability to pay, price could no longer control demand. Scarcity still remains though, as does opportunity cost – a pound spent on health cannot be spent on other socially desirable goods such as education or infrastructure.

Overall demand for health care has not only expanded but also changed in nature. The tackling of the major communicable diseases also revealed — and may have helped feed — a deeper well of ill health, particularly among an ageing population. Less-easily curable illnesses associated with chronic, long-term conditions such as cardio-vascular disease, cancer, diabetes and obesity that often involve expensive long-term health support have increased. Pharmacological and technological innovation has brought hitherto unapproachable disorders into the realms of therapeutic possibility. The development of imaging technologies, multi-factorial risk algorithms and genomic medicine are enabling the prediction of future diseases in otherwise healthy or asymptomatic patients with a corresponding increase in prophylactic or anticipatory treatments. Without regulation by price, such escalating demand can be managed by either increasing the budget, rationing supply, or by increased efficiency. In search of efficiency gains, policy makers turned toward market models – could some forms of competition within the health economy drive down unnecessary costs enabling more care to be delivered from the same budget?

Along with the search for efficiency, market models, particularly patient choice, were called upon to improve both the quality of care and patients’ experience. Where patients do not pay for services themselves and their choices will not therefore be influenced by cost, it is argued that providers will be forced to compete on quality — both clinical quality and the quality of patient experience. If patients could choose their service provider, and if those providers were paid a fixed sum for each episode of care, then, according to market logic, those providers would compete on the basis of quality and experience: patients would simply vote with their feet. ‘Natural’ monopolies, like the NHS are also said to be poor innovators: the monopolist’s protected position means they are under no economic pressure to innovate. Through unbundling NHS-provided services and encouraging small suppliers to compete for niche markets within health, it is said that innovation will lead to improved quality for patients.

This ‘choice’ agenda found particular favour with New Labour after 2002 following the introduction of a small number of pilot projects for elective conditions with long waiting lists, such as cataracts and orthopaedic surgery. Patients were said to see themselves increasingly as consumers rather than passive recipients of health services. Choice was seen as promoting patient autonomy with healthcare increasingly conceived as a partnership between patients and health providers. There was concern among New Labour policy theorists that patients were becoming intolerant of the dirigisme of traditional public services with their inflexibility, uniformity and unresponsiveness. There was a perceived danger that unless health services became more sympathetic to individual needs, those with disposable income — overwhelmingly the middle classes — would turn to private health care, potentially exacerbating health inequalities and shifting key voters away from the NHS.

These changes have also taken place against the global rise in the last thirty years of neo-liberal economic theory. Neo-liberalism harks back to Adam Smith’s The Wealth of Nations (1776) and the Victorian liberalism that it helped engender. It asserts that the free functioning of market forces leads to a more efficient allocation and use of resources,
guarantees maximal preference satisfaction, higher economic growth and thus leads to an increase in overall welfare. It stresses the centrality of individual choice and the importance of minimal state intervention in economic and social life. Influential in this ascendency of post-War neoliberalism was the work of the Austrian philosopher F.A. Hayek. Hayek drew on his personal experiences of European totalitarianism to assert that the centralised direction of economic activity leads inexorably to state-sponsored tyranny and a catastrophic loss of individual liberty.6 Hayek’s work was picked up in England by the Thatcher government as part of a sustained critique of both Keynesian post-War economic interventionism and the social democracies that were its political twin.7 It is probably fair to say that the debate over the introduction of market mechanisms into the NHS has been characterised by sharp ideological positions that can obscure a clear-eyed assessment of the pros and cons of the changes. Defenders of market mechanisms have at times seemed pre-convinced of their benefits, despite the real challenges involved with deploying them in a centrally-funded health system free at the point of need. Opponents have sometimes seemed opposed to commercial mechanisms as such — often because of the broader equity impacts of markets in general — irrespective of any benefits they may, in some contexts, be able to deliver.

Case example: markets and moral hazard – providing public subsidies to Independent Treatment Centres

The provision of public services does not necessarily lend itself to classic market structures. In order to make the provision of these services commercially attractive, public money is sometimes used to underwrite the risks of private sector entry. Under the New Labour government, commercially-run Independent Sector Treatment Centres were encouraged to provide NHS-funded diagnostic and elective care services such as cataract and knee surgery. During the early phases of the scheme, the ISTCs were paid, on average, 11.5% more for each operation than the equivalent cost to the NHS at a cost of around £130 million. ISTCs were also guaranteed payments irrespective of whether they carried out the contracted number of procedures. The Department of Health also guaranteed to buy back some of the treatment centres after five years.8 Given that the risk of commercial failure is said to be one of the great drivers behind innovation and the search for efficiency gains, the use of public subsidies to provide a guarantee against it could be said to distort the ordinary incentives of a market. It also introduces the risk of moral hazard. As discussed below, in economic theory, moral hazard arises where one party gets involved in an undertaking that involves risk knowing that another party to the transaction will bear any costs arising from it. Moral hazard can result in the development of incentives that are at odds with ordinary market disciplines.

The nature of market mechanisms in the NHS

The terms ‘market’ and ‘market mechanisms’ can be ambiguous, as can allied terms such as ‘patient choice’, ‘privatisation’ and ‘commercialisation.’9 In the NHS the term ‘market mechanisms’ ranges from the use of private providers in the delivery of publicly-funded healthcare — sometimes referred to as ‘outsourcing’ — to the use of market-type incentives within publicly financed and provided NHS services. At its extreme it is sometimes used to refer to the wholesale privatisation of the NHS and the abandonment of the principle that healthcare should be free at the point of delivery.

Arguably the introduction of market-type reforms in the NHS reaches back to the development of an ‘internal market’ in the NHS by successive conservative governments in the eighties.10 In turn, the origins of the internal market lie at least in part with the work of Alain Enthoven at the Stanford Business School who published an influential report on the search for efficiency gains in the NHS.11 Enthoven argued that although the NHS was much loved and provided a great deal of care for the expenditure, resource constraints meant that efficiency gains would inevitably have to be sought. In his view, the NHS in the 1980s lacked knowledge of its own costs and was subject to no significant incentives to improve
care quality and reduce those costs. Several of Enthoven’s recommendations have become established features of the NHS. They include:

- competitive tendering from commercial companies for catering, cleaning and laundry services;
- the purchasing of acute care services from the commercial sector where they can be secured more cheaply than when provided internally;
- the provision of training in management to senior doctors;
- the purchasing and selling of services to and from large-scale NHS units — the ‘internal market.’

In addition to Enthoven’s recommendations, changes in the last decade that reflect a move towards more market-like approaches include the following.

- Introducing some form of payment by results.
- Extending patient choice among providers of care.
- Encouraging a mixed economy of ‘autonomous’ providers.
- The creation of NHS foundation trusts as part of the 2003 Health and Social Care Act. This legislation freed a number of NHS hospitals from direct control of the Department of Health and enabled them to borrow capital, sell assets and retain in-year surpluses. Governed by a board that includes representatives of their local community, foundation trusts are intended to be more responsive to local needs and have more autonomy to ensure those needs are met.
- Establishing independent regulation of providers.12

**How successful have the reforms been?**

It is an ethical commonplace that the — moral — justification for reforms on this scale must lie in the strength of the intended benefits and that those benefits must outweigh the inevitable costs, both economic and other costs. It is safe to say that the evidence relating to the success or otherwise of the reforms is both uncertain and contested. In 2014 Chris Ham published a report for the Kings Fund assessing their impact.13 It drew on the best available evidence and provided a nuanced description that is outlined briefly below.

- Studies of the internal market in the 1990s concluded that their impact was limited because the incentives were too weak and the constraints too strong. Foremost among these constraints was an unwillingness on the part of politicians to follow through on the logic of the reforms and allow NHS providers who failed to compete successfully to exit the market.14
- An evaluation of New Labour’s market reforms concluded that their impact was limited, while also noting that the adverse consequences predicted by opponents of competition and choice had not materialised either. An important overall assessment of the impact of different approaches to reform during this period observed that many of the gains made before and after 2002/3 were unrelated to competition, patient choice and the rest of the market reform package, being linked instead to increases in spending and the size of the workforce after 2000, together with strongly enforced targets, leading to improvements in performance.15
- The strongest evidence that competition in the English NHS delivered improvements in performance comes from two econometric studies of the relationship between provider competition and patient outcomes, focusing on death rates in hospitals after heart attack and other causes.16 A review of these studies noted that while death rates fell for all hospitals, they fell more rapidly in hospitals located in more competitive markets (Propper and Dixon 2011).17 What is not clear is whether competition caused this improvement in quality.
Market failure in health care

We have seen that since at least as far back as the Thatcher government, successive administrations have sought to tackle some of the challenges facing the NHS through the use of market-oriented mechanisms. We have also seen that the evidence of their effectiveness is both muted and contested. In addition though, there are a number of concerns, rooted in economic theory, as to whether, over and above direct equity costs, market mechanisms can ever be efficient – or even effective – in the provision of health care.

In a seminal article published in 1963, the economist Kenneth Arrow identified a number of reasons why markets in health care were prone to failure. To understand them it is necessary to be clear about how, ideally, markets are said to function. In economic theory, people make choices about purchases in order to maximise their utility or wellbeing. Buyers buy when their own expected utility is greater than the price; sellers sell when the price is greater than their costs. In order for markets to be effective though a number of preconditions need to be met. Buyers need to be very clear where their utility lies and how to maximise it in the marketplace. Likewise, sellers need access to information in order to decide where to invest. Price is the signalling mechanism. As long as prices are free to move, and information can be freely exchanged, prices will tend to rise where demand exceeds supply, thereby encouraging others into the market, and will fall where supply exceeds demand resulting in the less-competitive exiting the market. For the following reasons though, markets in health care are liable to failure:

1. **Informational asymmetry**— in ordinary circumstances, health professionals will have far more information about health states and services. In a pure market a doctor would be both agent and seller.
2. **The difficulties of commodification**— looked at economically, healthcare markets trade in illness, investigations and treatments. Unlike standard goods and services these are notoriously difficult to commodify and therefore to price effectively.
3. **Excess capacity is needed**— without excess capacity in the system choice cannot work. Unused capacity leads to inefficiencies.
4. **Market exit and entry is difficult**— hospitals and large clinics are expensive, complex buildings containing costly equipment and highly skilled, expensive staff.
5. **Price signals don’t work**— Payment often comes after treatment. Few people can afford the full cost of extended medical care, so risk pooling and other methods are required.
6. **Demand is not usually negotiated by consumers**— health professionals or commissioners are the ordinary purchasers of health care, not patients.

Much of the moral unease associated with the spread of markets in health care is linked in some degree to these market failures. The problem with informational asymmetry speaks to the vulnerability of at least some patients as hypothetical ‘purchasers’ of health care – in a direct market those who purchase health care may not have as much knowledge as those who ‘sell’ it. The commodification and pricing of services linked to such a key aspect of human wellbeing, although economically rational, triggers moral qualm. Similarly, the prospect that large providers of key public goods, such as large hospital trusts, could be vulnerable to market failure and therefore, potentially, deprive significant populations of access to essential health goods is morally unappealing and – probably – politically unacceptable. Arguably as well there is an inherent tension between strict market rationality and the obligations of health professionals to their patients and it is to the large potential implications of that tension that we now turn.

Although it is not easy to conclude a discussion as complex and morally charged as this, some tentative suggestions can be made. Given that demand for services in the NHS significantly outstrips available supply, the search for efficiency savings is necessary. Markets have shown themselves in some contexts as effective means of allocating resources. Clearly though questions remain about how effective they can be in a publicly-funded health system free at the point of need. Further research into their effectiveness – and into potential negative consequences – is required.
Case example: Hinchingbrooke Hospital – public goods and commercial failure

Hinchingbrooke hospital in Cambridgeshire identifies some of the hazards of large-scale commercial engagement in the delivery of public services. In November 2011 it was taken over by Circle Health, a private company. Not long into the contract reports emerged that Circle was facing financial problems and was struggling to make the anticipated cost savings. In 2014 the hospital was rated ‘inadequate’ by the Care Quality Commission (CQC) and was placed under ‘special measures.’ In January 2015 Circle announced that it would pull out of the contract, citing funding cuts and excess demand for A&E services. Commercial failure of this kind presents a number of challenges to the provision of public services. Given that commercial companies have fiduciary obligations to transfer value to shareholders, efficiency gains need to be significant in order to both invest in services and pay dividends. Because their primary obligation is to shareholders rather than the populations they serve, commercial companies can suspend services. This creates straightforward problems with continuity of care. But it also involves the possibility of moral hazard. If commercial companies know that they will always be able to withdraw from service provision, there may be less incentive for them to invest in sustainable, long-term solutions focused on the needs of the population.
Part two: the impact of market mechanisms on the culture of the NHS

The first part of this paper looked at the nature of the market mechanisms being introduced to the NHS and the extent of their economic effectiveness. Changes of this scale and nature also have an impact on the culture of an organisation, including its values and, potentially, its purposes. In turn these can have significant ethical implications. These are complex and controversial issues. This part of the paper highlights some key areas of concern that require consideration.

Markets and professional obligations to patients

Although doctors have always been paid, medicine is a morally-inflected practice. Its purpose is to promote human wellbeing and it is easy to see how the single-minded pursuit of profit by medical practitioners would be in tension with this primary goal. There is a clear danger that a market ideology privileging individual choice and the maximisation of profit can undermine obligations to patients. Historically, managing these tensions has been seen as an aspect of medical professionalism — that doctors internalise core patient-oriented medical values and therefore manage the tensions appropriately. For this reason, the professions were seen by some commentators, including Emile Durkheim, as standing in some degree over against markets, and providing a check on their ethically more destructive potential. During the last century or so, medicine has increasingly been practised in large and complex institutions. These institutions increasingly structure medicine and their impact on both professional norms, and ethical practice, is likely to be significant. This section looks at the possible implications of widespread use of market models in the NHS on medical professionalism. It also looks at the emergent discipline of institutional ethics.

Trust and medical professionalism

Although the concept of medical professionalism is not easy to define, there is a strong consensus that at its moral centre lies the relationship between the doctor and patient. To borrow a legal term, this can be thought of as a fiduciary relationship: the doctor as fiduciary is bound by the obligations of the profession to act for the benefit of his or her patient. Although doctors will almost always have other, sometimes competing, obligations, these will usually be in the background. In ordinary circumstances, the doctor’s primary duty is to the patient and to the promotion of his or her health and wellbeing.

Ethically and legally, a fiduciary relationship is based on trust. Traditionally, the doctor-patient relationship has been understood to involve a mutual and reciprocal set of duties and obligations — that the doctor, for example, will act in the best interests of patients, that patients will ordinary tell the truth, and, following agreement, will seek to comply with treatment regimes. Fiduciary relationships seem well-suited to the medical profession. They have an open-ended aspect. Unlike a contractual relationship, one based on trust means that in the ever-uncertain future we do not have to worry as to whether we have spelt out the detail of our expectations as patients or our obligations as doctors. As the philosopher Onora O’Neill writes, given the radical uncertainty of the future, trust is vital because ‘we have to be able to rely on others acting as they say that they will, and because we need others to accept that we will act as we say we will’. But as O’Neill points out, there is a widespread contemporary perception that trust in our public institutions, including medicine, is under siege, that we simply no longer place our trust in professionals with the same certainty. O’Neill points out that the evidence for this, including the evidence from our behaviour, is uncertain at best. She also argues that the remedies we seek — ever greater regulation and accountability — may in fact further dilute the trust they seek to strengthen. As we go on to see, however, there is a real possibility that placing the doctor-patient relationship in an increasingly commercialised context can have an impact on the mutual trust that should, ideally, underlie it.
Case example: the impact of a competitive market on the health workforce – Mid Staffordshire and the lessons from social care

There were many factors behind the catastrophic failure of care that Robert Francis identified in his report on Mid-Staffordshire NHS Trust. Among them were intense pressures to keep costs down and the resulting use of unregulated and poorly paid assistants and ‘auxiliary workers’ to provide nursing care. A government report found that during 2011-12 there was an increase in the numbers of auxiliary staff employed in the NHS but an overall decrease in the number of nurses. This has led to auxiliary staff taking on increasingly complex procedures. There is clear evidence that the marketization of social care services has led to the growth of a very large, unregulated and poorly paid workforce. The extent to which the impact of marketization on social care is predictive of what will happen in a more commercially-oriented NHS is moot. At its professional end, medicine is far more highly skilled, subject to greater regulation, and, as we know, has stronger professional and trade union support. But good care also depends on the support of less-highly skilled staff who may have less professional backing. Also the government was clear that one of the attractions of greater private sector involvement was that they were not subject to NHS terms and conditions. The extent to which private sector contracts might mitigate against ordinary professional obligations is an ongoing area of concern. There is some anecdotal evidence to suggest that commercial confidentiality for example has restricted the access to appropriate information about private-sector health outcomes. Unlike their NHS counterparts, private sector providers are not, for example, obliged to comply with freedom of information (FOI) requests, although their commissioners are.

The principal-agent relationship

The concept of professionalism, with its link to an ethics rooted in the virtues of doctors, is only one way of configuring the nature of reciprocal obligations between health professionals and their patients. There has been important recent work in economics and law that sees medicine as an example of the principal-agent relationship. This is understood where an individual – the principal – engages another person – the agent – to undertake some action or service on their behalf involving some degree of delegated authority. Given that other professions, such as lawyers and accountants, have always been predominantly commercially-oriented, this could be a useful model to explore as medicine becomes increasingly subject to market-type pressures. Interestingly, one of the big ethical challenges in the principal-agent relationship is how to ensure that the agent acts in the principal’s interest rather than their own, something strongly echoed in ethical concerns about proliferating conflicts of interest in medicine.

In 2006-7, Relman, a former editor of the New England Journal of Medicine, wrote a commentary in the Journal of the American Medical Association describing what he saw as a ‘crisis in medical professionalism in the USA,’ a crisis being driven by the ‘growing commercialization of the US healthcare system.’ Relman writes:

Physicians have always been concerned with earning a comfortable living, and there have always been some who were driven by greed, but the current focus on moneymaking and the seductions of financial rewards have changed the climate of US medical practice at the expense of professional altruism and the moral commitment to patients. The vast amount of money in the US medical care system and the manifold opportunities for physicians to earn high incomes have made it almost impossible for many to function as true fiduciaries for patients.

Although it can be difficult to draw direct comparisons between very different healthcare systems – and very different healthcare cultures – it is interesting that Relman’s comments emerge in a system with a long history of market involvement in health care. The changes
did not come about with the inauguration of a market, but with its intensification – with what might be seen as a change in the balance of powers between medicine as a profession and medicine as a commercial enterprise. For Relman, the size of the commercial involvement, and the scale of potential profitability threaten to destabilise professional values.

**Case study: A servant of two masters? Doctors employed by commercial companies**

The primary purpose of commercial organisations is to make money. Where commercial organisations have shareholders, this obligation is expressed as a duty to act in the financial interests of those holding the shares. In contrast the primary purpose of a public service such as the NHS is to realise the public good or goods to which it is directed. Although public services are subject to cost constraints, and are forced to prioritise activities, these decisions are not antagonistic to their primary purpose; they are necessary side-constraints. Doctors working in NHS providers have to operate within these constraints, but their professional obligations remain allied to the organisation’s core purpose. Doctors employed by commercial companies are, of necessity, in a different set of arrangements. Although commercial health providers are unlikely to succeed if they do not provide good care, there will be times when professional obligations to patients will come into tension with the search for profitability. When profits are threatened in commercial organisations, pressures to reduce costs, and to seek activity that will maximise profit, can be intense. In a health context there is a risk that this could lead to significant downward pressure on standards of medical care.

**Conflicts of interest**

In the UK, since the inauguration of the NHS, the majority of doctors and other health professionals have been insulated from direct financial incentives, and wider commercial or market-type pressures. To a considerable degree, the institutions of medicine in the UK have, at their best, been aligned with core professional values – at worst they have seldom been openly or directly antagonistic to them. It is probably fair to say that we are now moving into largely uncharted territory. What is already clear is that the changes are introducing conflicts of interest on a new scale. Conflicts of interest arise for doctors when they become involved in arrangements that may be in tension with their primary obligation to the best interests of their patients. Some of the areas in which these conflicts have given rise to concern are discussed below.
**Case study: the use of financial incentives to manage referral rates**

It is a truism to say that financial incentives are used to shape behaviour in commercial enterprises – desirable activity is often directly rewarded by payments or other transfer of value. In the NHS, decisions made about the provision of health services, such as referrals, can have significant financial implications. Similarly, where patients successfully engage with preventive health care or lifestyle changes, the cost savings can be significant. Incentives are increasingly being deployed in health care in order to promote cost-saving behaviours in these and other contexts. In the example below we highlight some of the ethical issues associated with the use of incentives in commissioning.

Middlecounty CCG has identified that in relation to national averages it has a high rate of GP referral to secondary care. At a time of sharp fiscal constraint such high referral rates have significant budgetary concerns. Dr Middleband has been asked to develop some proposals to try and reduce referral rates. Concerned not to transfer referral decisions to a triage and assessment service, the CCG has particularly asked Dr Middleband to see whether effective use could be made of financial incentives.

Referral practices are complex and multifactorial and will always depend upon a variety of legitimate factors, both clinical and non-clinical. However, having carefully assessed local referral practices he has identified that there is some ‘discretionary’ or potentially avoidable referral activity. Some patients referred to consultants could have been managed by GPs or by non-consultant-led services in the area.

In considering the use of financial incentives to encourage different referral patterns, Dr Middleband rejected any consideration of direct payments to individual GPs. Any such payment would introduce strong conflicts of interest and would be in breach of GMC guidance. Although he found some evidence that the offer of financial incentives to practices could be effective in altering behaviour in ways that benefited patients, there were still risks. Potential conflicts of interest remained, although more muted. Any perception that doctors were paid to change referral decisions could also undermine trust. Many GPs felt extremely uncomfortable about such incentives, arguing that it could be perceived to undermine their professional judgment.

On this occasion Dr Middleband decided that it would be preferable to set up a system involving periodic peer review and feedback sessions directed at referral practices.

**Commissioning**

Changes introduced by the Health and Social Care Act 2012 (HSCA) have transferred responsibility for allocating the bulk of the NHS commissioning budget to consortia of local GPs known as clinical commissioning groups (CCGs). Since April 2015 CCGs have also been able to take an enhanced role in GP service commissioning. Among the explicit goals of these changes was the desire to transfer the commissioning of local services to those with the most in-depth knowledge of local health needs. As GPs are responsible for the bulk of patient referrals, giving them control of the commissioning budget was also intended to introduce cost-awareness into referral practices. GPs would also be in a position to offer treatment to NHS patients in out-patient clinics, or to manage care based in the community, thereby generating cost savings.

Although these are rational objectives, given that GP practices are private contractors to the NHS, many GPs have clear financial interests in the services they provide and may also hold investments in other local health providers. As a result, the HSCA gave rise to significant, and predictable, conflicts of interest. The subsequent introduction of enhanced commissioning arrangements meant that, where they are members of relevant CCGs, some GPs would be involved in commissioning services from their own practices.
Given the size of the commissioning budget, and the increasing emphasis on probity and transparency in public life, such significant scope for conflicts of interest entails risk to public trust in the health service. Perception is crucial to trust and media reporting of even low levels of misuse of public funds by commissioners could result in system-wide doubts about integrity. As a result, attention has turned to the identification and management of conflicts of interest. In the case study below we show how conflicts of interest naturally arise during the commissioning process and how the associated risks can be managed.

**Case study – CCG commissioning of specialist services: managing conflicts of interest**

Westbury CCG is looking to develop its specialist sexual health services. A proposal is independently developed by Dr Clerk. He is a partner in one of the CCG's member practices but otherwise has no involvement in the CCG. As a doctor with a special interest in sexual health, it is appropriate, given his expertise, for him to develop such a proposal. However, it is also likely that he would be in a strong position to win any tender.

**Risks**

Dr Clerk has a direct financial interest in the proposal he is putting forward to the CCG. If inappropriately declared and managed, there is a risk that the CCG will be perceived to be putting the interests of a member practice first. This could lead to legal challenge from other providers, as well as potentially undermine public trust and confidence.

**Managing the risk**

Although unavoidable, a conflict of interest as potentially significant as this, needs to be properly declared and managed. This should include the following:

- Dr Clerk’s interests should be stated in the CCG’s register of interests and in any discussion involving the proposal, as should the interests of the partners in his practice
- The proposal to develop sexual health services must be based upon clear and justifiable reasons, including a needs assessment and appropriate patient engagement
- Other specialist and potential providers of sexual health services have been appropriately involved in the development of the proposals
- The proposals have been subject to appropriate scrutiny, public and stakeholder engagement, and any new services are commissioned by in accordance with procurement rules.

**Organisational ethics**

In a 2012 paper in the Journal of Medical Ethics, Lucy Frith, commenting on the market-oriented reforms in the NHS, discussed the need for an examination of what she described as the impact of the changes on the ‘organisational ethics’ of the NHS. Frith describes organisational ethics as:

...the examination of the ethical implications of organisational decisions and practice on patients, staff and the community.26

As with much contemporary bioethics, organisational ethics developed in the US, specifically in response to large scale changes in the organisation and financing of health care. Unlike traditional medical ethics, which has largely focussed on the doctor-patient relationship, organisational ethics looks at a wider range of interests. According to Frith, important questions from an organisational ethics perspective include:
What are the organisation's alleged aims and values (sometimes contained in a mission statement)? How does the organisation behave ethically in its financial and business arrangements? What are the organisation's work practices, policies, promotion criteria, organisational structures? How does the organisation manage conflicts of interest? What are an organisation's duties to its stakeholders? How do the organisation's activities affect the wider community?

A key component of an organisational ethics approach is its use of stakeholder theory, an approach adapted from business ethics. According to Frith, stakeholder theory:

… is useful for thinking through: the obligations (and limits of these) of an organisation; who counts as a stakeholder; the parameters of these obligations (both internal and external to an organisation); and the relationships between stakeholders (the organisation and its patients, its staff and staff and patients). As Werhane sums up, 'Stakeholder theory provides a moral framework for evaluating not only stakeholder relationships but also evaluating organizations, their missions, and their value-creating activities. Thus stakeholder theory initiates thinking about organization ethics for healthcare, while including the stakeholder dimensions of professional, clinical, and managerial ethics.'

Although such an approach takes us well beyond the ordinary purview of medical ethics — and into a new technical language — in Frith's view it can augment and enrich an understanding of the implications of widespread NHS change for clinical relationships and concepts of professionalism, incorporating the ethical implications of systemic change wherever they are felt, both within the institutions themselves and amongst the communities they serve.

Health and health services as commodity

As mentioned earlier, the debate around market-oriented reforms in the NHS in England has often gone beyond the question of whether markets can, practically-speaking, deliver the benefits their proponents promise. The debate has also asked whether there is something more constitutively incompatible between health services and commercial models, even where those services are not bought by their users on an open market — that they remain to some degree free at the point of use. The moral arguments here can be quite complex. Although a free market in health services would have clear equity costs, if NHS treatment remains free, why should it matter if it is commercially or publicly provided? In this final substantive section we ask the more speculative question of whether there is something inherently antagonistic between health services and commercial provision.

The American moral philosopher Michael Sandel has written extensively about the moral implications of the progressive expansion of the market into more and more aspects of modern western culture. According to Sandel:

The reach of markets, and market-oriented thinking, into aspects of life traditionally governed by non-market norms is one of the most significant developments of our time.

Sandel argues that there are two main moral concerns with the expansion of market-oriented thinking. The first has to do with equality and fairness. The more areas of our lives that become governed by markets, the more important money becomes and the more difficult life is for those with modest means.

More immediately relevant to our interests is his second concern. He admits that it is more difficult to describe but goes on to say:
It is...about the corrosive tendency of markets. Putting a price on the good things in life can corrupt them. That’s because markets don’t only allocate goods; they also express and promote certain attitudes toward the goods being exchanged...Economists often assume that markets are inert, that they do not affect the goods they exchange. But this is untrue. Markets leave their mark. Sometimes, market values crowd out nonmarket values worth caring about.

In the UK, the NHS is often held by its champions to be a strong example of social solidarity – of an agreement to pool the risks of ill health. One of the reasons why the introduction of markets into the NHS is looked at with such suspicion is to do with their individualistic nature – that markets are oriented toward individual preference satisfaction rather than the promotion of social solidarity.

The extent to which Sandel’s arguments, drawn from a US context, are directly relevant to the UK is perhaps an open question. The NHS emerged from commercial provision and GPs have always been independent of government. Arguably though, Sandel’s insights have some significant bearing on the debate about marketization in the NHS. If market models are not neutral mechanisms, but carry significant normative weight, then any potential efficiency gains – which, as we have seen, are not strongly supported by evidence – may need be weighed against unintended, and for some deeply unwelcome, changes in culture and ethos.

Case example: Richard Titmuss – The Gift Relationship

In 1970, Richard Titmuss, a British sociologist, published a classic account of the ethics of blood donation, *The Gift Relationship*. He compared the system used in the United Kingdom, where blood is donated free, with the system in the United States where some blood is donated and some bought by commercial blood banks. Despite the alleged distributive efficiency of markets, Titmuss, drawing on a large body of data, demonstrated that the British system was more effective. Even on a practical level, he argued, the American system led to chronic shortages, higher cost, greater wastage and an increased likelihood of contaminated blood. He also raised two ethical concerns. The first had to do with fairness: commercialising the blood supply in America meant that considerably more blood was donated by those in economic hardship. In Titmuss’s words, one of the primary effects of the American system was a redistribution of blood ‘from the poor to the rich’. Secondly, the commercialisation of the blood supply undermined what Titmuss called, ‘the gift relationship’, replacing bonds of solidarity with commercial exchange. While, as Michael Sandel points out, a market in blood doesn’t stop people donating, “the market values that suffuse the system exert a corrosive effect on the norm of giving.”
Conclusion
The NHS in England has, for thirty years, been subject to increasing market-oriented supply-side reforms. These reforms have been driven by the need for efficiency savings and the desire to improve patient choice and satisfaction in the health service. Although markets are highly efficient at allocating resources in some circumstances, the extent to which a supply-side market in publicly-funded health care can be effective according to the desired outcomes, remains, currently, unproven. Economic theory has identified that markets in health are prone to failure, many in ways that can be detrimental to patient interests. Although there has been considerable research on the direct effectiveness of markets in the English NHS, discussion about the ethical and professional implications of a move to more commercially-oriented practice has been more muted. In this paper we have identified a number of ethical concerns. In addition to poor evidence of effectiveness, there are well-founded questions about the impact of commercial models of delivery of medical professionalism and on trust in the doctor-patient relationship. Obvious examples of this have included the potentially detrimental effects of targets and incentives, as well as the proliferation of conflicts of interest in the new commissioning environment. Finally there is the question about the social desirability of the increasing commercialisation of public services, including health. By subjecting certain social goods, such as health care, to market forces there is a potential to change the nature of the good itself. Markets may not always be ethically neutral systems of exchange. They may alter the value of what is exchanged.
References


