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DISTRIBUTING HEALTH CARE: RATIONING AND THE ROLE OF THE PHYSICIAN IN THE UNITED KINGDOM NATIONAL HEALTH SERVICE

Alan Maynard[†]

INTRODUCTION

THE POLICY ISSUE is not whether to allocate or “ration” health care, but how, *i.e.*, what rules will be used by society to determine access to care? These rules will decide who will receive treatment, who will live in pain and discomfort and who, in extremes, will be left to die. Such decisions are never easy for consumers, providers, purchasers and policy makers.

This article will review these issues in the context of the United Kingdom National Health Service (“NHS”). In the first section, the goals of the NHS will be examined in terms of the principles enunciated in legislation. The next section will look at the practice of rationing in the NHS, processes with characteristics well-known to all who are familiar with the practice of medicine! In the third section the role of physicians in the rationing processes will be examined.

THE GOALS OF THE NHS: THE PRINCIPLES OF RESOURCE ALLOCATION

The White Paper of the Churchill Government in 1944 stated that:

[T]he Government . . . wants to ensure that in the future every man, woman and child can rely on getting . . . the best medical and other facilities available; that their getting them

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shall not depend on whether they can pay or on any other factor irrelevant to real need.¹

In 1946, an outline of the Labor Government's NHS Bill stated that the Service "imposes no limits on availability, *e.g.*, limitations based on financial means, age, sex, employment or vocation, area of residence or insurance qualification."²

Even for these Labor Party legislators there were limits to the generalization that services were to be free. The exceptions in the initial legislation were threefold:

- a) Charges were to be levied for the repair of spectacles and appliances broken as a result of negligence;
- b) Payments were to be made for services and appliances provided at levels or standards above the general service level (*e.g.*, amenity beds and private NHS hospital beds);
- c) Charges were to be made for domestic help and some related services.³

Aneurin Bevan, the Labor Party's left wing architect of the NHS, resisted amendments to make domestic help and related services free during the passing of the legislation. This dedicated socialist argued in an almost Thatcherite fashion:

I really must resist this amendment. Does the Hon. Member suggest that everything shall be free? . . . It is a perfectly reasonable proposition that, where domestic help of this sort is needed and the persons concerned are able to provide it for themselves, they should do so, and where they are able to make a contribution, they should make it . . . it seems to me to be wholly unjustified that we should provide a service of this sort without any payment whatever. . . . Our objection to the means' test was that it was devised for the purpose of withholding money from people. This means test is for the purpose of giving services to people who are in need of these services . . . and where people can make a contribution towards the cost, they should make it.⁴

1. MINISTRY OF HEALTH, *A NATIONAL HEALTH SERVICE*, CMD. 6502, *reprinted in* RODOLF KLEIN, *THE POLITICS OF THE NATIONAL HEALTH SERVICE* at 10 n.10 (Longman 1983).

2. MINISTRY OF HEALTH, *THE NATIONAL HEALTH SERVICE BILL: A SUMMARY OF THE PROPOSED SERVICE*, 1946, Cmd. 6761.

3. *Id.*

4. Committee State of the National Health Service Bill, House of Commons Debates, June 18, 1946 HANSARD cols. 1561-62.

Rhetoric and ambiguity are the hallmarks of political debate and the precise definition of what is being rejected and what is being accepted is usually absent. Such vagueness makes it difficult to hold elected officials accountable and makes the monitoring of their performance and that of health care managers and clinicians very difficult.

It is perpetrated in more recent times. The ideology of the Thatcher government was libertarian. Normally, this would mean that the government would regard access to health care as part of society's reward system, with people permitted (if not encouraged) to use their income and wealth to gain better health care, if they wish, than their fellow citizens in similar circumstances. The logical consequence of the libertarian ideal would be that private practice would predominate, with a "residual" NHS providing a minimum standard of care for the poor. Inequality in access to care is an inevitable consequence of the market. Indeed, it is a sign of its success!

In this market "ideal," the consumers would judge the system's success by its ability to do what they demand at a time and place, and in a quantity and quality they require. Producers would judge the market's success by their ability to make a good income out of it.

However, the "real" health care market does not work like this. Doctors act as the patients' agent, mediating their demands for health care. The consumers' capacity to access care is determined by the reimbursement rules of the insurers and utilization is constrained by anxieties about "medical indigency" and the fear that insurers will adjust the risk rating of those consumers who demand "too much" care.⁵

The complexities of how the "real" health care market works and the political popularity of the NHS constrained the pro-market element in the Conservative government and, as a consequence, Margaret Thatcher argued, at the Conservative Party Conference in Brighton on October 8, 1982 in the 1983 Election Manifesto, that "the principle that adequate health care should be provided for all, regardless of their ability to

5. See A. Maynard & A. Williams, *Privatization and Health Care*, in *PRIVATIZATION AND THE WELFARE STATE* (J. LeGrand et al. eds., 1984).

pay, must be the foundation of any arrangements for financing health care."⁶

During the debates in 1989-90 about the reform of the NHS, Mrs. Thatcher argued that an efficient NHS would drive the private health care sector out of business.

If scarce health care resources are not to be allocated (*i.e.*, rationed between competing patients) in a private market according to the willingness and ability to pay of patients and private insurers, what criteria are to be used? The founding fathers (and mothers) of the NHS wished to allocate health care according to need. This is set out clearly in the legislation.⁷ But how does one define "need?"

Doctors and managers in the NHS treat patients who are present due to accident or illness, or because physicians, as a matter of policy, seek out patients for care (*e.g.*, breast cancer screening). More patients present for care than can be treated.⁸ Furthermore, due to demographic change and technological innovation, the number of potentially beneficial treatments is increasing and, as a consequence, the gap between what can be done technically and what can be afforded financially is widening.⁹

The rationing process in the NHS ideally should consist of two steps:

- 1) A Technical Judgement: Which patients would benefit most from care in terms of enhanced duration and quality of life (*e.g.*, quality adjusted life years = QALYs)?¹⁰
- 2) A Social Judgement: Is it worthwhile to treat patients (*i.e.*, how much will society pay to purchase an additional QALY)?

The medical experts should provide technical information about the comparative QALY performance of competing therapies (Step 1). In a society with a national health service, the

6. Margaret Thatcher, Speech to the Conservative Party Conference, October 8, 1982.

7. See *supra* notes 1, 2 and accompanying text.

8. See, *e.g.*, Jeffery Haller, *Britain's Labour Party Launches Offensive on Health Service*, REUTERS, January 6, 1988 ("Thousands of Britons have been waiting for operations for more than a year. . .").

9. KLEIN, *supra* note 1, at 81-2.

10. See *Rationing Health Care*, THE ECONOMIST, April 23, 1994, at 17 (explaining QALY analysis); see also Ray Robinson, *Cost Utility Analysis; Economic Evaluation and Health Care*, 307 BRIT. MED. J. 859 (1993).

politicians, as representatives of the taxpayer, should decide how much treatment to fund (Step 2). Technical judgements would prioritize competing treatments, identifying the "best value for money." Funding judgements would decide how far down this league table it will be possible to fund treatments. Below some "plimsoll line," beneficial treatments would not be funded and patients should be left in pain and discomfort, and to die. Treatment in an ideal NHS, therefore, would be allocated according to the patient's capacity to benefit from care and in a manner similar to that attempted in Oregon,¹¹ discussed in the Netherlands and explored in New Zealand.¹² It also may involve, as in Oregon, the use of truth those patients refused access to care and to be told it is due not to the absence of effective therapies, but to the lack of finance.¹³ Such honesty may increase pressure for increased funding of, hopefully, cost-effective care.

THE GOALS OF THE NHS: THE PRACTICE OF RESOURCE ALLOCATION.

The principle of resource allocation, the benefit principle, distilled from the legislation and the legislators' statements require the clinicians and managers in the NHS to identify what works (i.e., the cost-effectiveness of competing interventions) and deliver, with the assistance of suitably designed incentive systems, those services which give the "biggest bang for the buck."¹⁴ This is easier said than done!

The health care system in the U.K. is similar to that in any other country: cost data are poor, there are large variations in clinical practice, the little effectiveness data that exist tend to be ignored, often for many years, and the majority of health care services in use have no proven scientific basis.¹⁵

11. See, e.g., THE BROOKINGS INSTITUTION, *RATIONING AMERICA'S HEALTH CARE: THE OREGON PLAN AND BEYOND* (Martin A. Strosberg et al. eds., 1992).

12. See Chris Ham, *Priorities: When Health Care Goes on the Ration*, THE GUARDIAN SOCIETY PAGE, Nov. 9, 1994, at 7; GOVERNMENT COMM. ON CHOICES IN HEALTH CARE, NETH. MINISTRY OF WELFARE, HEALTH AND CULTURAL AFFAIRS, *CHOICES IN HEALTH CARE*, DUNNING REPORT (1992); HEALTH CARE REFORMS GROUPS, N.Z. COMMUNICATIONS UNIT, *HEALTH CARE REFORMS REPORT NO. 9* (Apr. 29, 1992).

13. See Ham, *supra* note 12; THE BROOKINGS INSTITUTION, *supra* note 11.

14. KLEIN, *supra* note 1, at 81-2; see also *id.* at 102 n.44.

15. See Steve Iliffe & Ulrich Feudenstein, *Fundholding: From Solution to Problem: United Kingdom's NHS Funding Reforms*, 308 BRIT. MED. J. 3 (1994); Chris Ham, *Prior-*

The NHS is seen by many Americans as a socialized system of health care delivery. While it may be fun to use such rhetoric in the polemics of the political market place, it has little basis. Until recently there has been an implicit agreement, described by Rudolf Klein, between the doctors trade union otherwise known as the British Medical Association ("BMA") and the government that the BMA would not challenge on funding issues provided the Government did not challenge on issues of clinical practice.¹⁶ This concordat survived until the 1980s and meant that clinicians determined both who they treated and how.¹⁷ This discretion remains even after a decade of Thatcherism and means that the freedom of U.K. clinicians is generally greater than that of their American peers working in a "free market."¹⁸

Clinical freedom in a broad sense is complemented in the NHS by poor data about costs. In the U.S. there are price data (which do not reveal costs, of course!), but in the U.K. the finance systems until recently were designed solely to facilitate expenditure control and adherence to cash limited budgets; they were not designed to inform anyone about the cost of procedures.

This absence of cost data is accompanied by poor process data. There are many hospitals in the U.K. that still do not have efficient patient administration systems and, as a result, it is not easy to identify bed occupancy characteristics.¹⁹ Until 1985 there was a national system of activity data — the hospital activity analysis. This was "redisorganized" in 1986 when

ity Setting in the NHS: Reports from Six Districts; *The United Kingdom's National Health Service*, 307 BRIT. MED. J. 435 (1993).

16. KLEIN, *supra* note 1, at 16-17 (describing the origins of the National Health Service); *id.* at 22-23 (detailing BMA discontentment); *id.* at 23-24 (describing the history of Bevan's concessions to physicians in 1948); *id.* at 86-90 (detailing the 1966 compromise and the implementation of the "Family Doctor Charter").

17. *Id.* at 121.

18. SHIRLEY ROBIN LETWIN, *THE ANATOMY OF THATCHERISM* 216-19 (1992) (describing the "internal market" of the National Health Service).

19. See PAUL KIND, *HOSPITAL DEATHS—THE MISSING LINK: MEASURING OUTCOME IN HOSPITAL ACTIVITY DATA 2-4* (University of York, Centre For Health Economics, Health Economic Consortium, Discussion Paper 44 1988) (describing the inadequacies of current data collection methods). See also *id.* at 1, 27 (further illustrating the impact of the lack of hospital outcome data).

the Korner information system was introduced, and as a result there has been no national data since!²⁰

The data from ad hoc studies show, as in the U.S. from Wennberg's work, large variations in activity rates.²¹ Some surgical activity data from McPherson's work is shown in Table 1. Remarkable variations exist, even for so-called "emergency" procedures such as appendectomy. A recent study of the use of diagnostic dilation and curettage ("D&C") in young women showed that D&C rates in England were over six times the U.S. rate: a large proportion of this activity is believed to be ineffective.²²

TABLE 1. VARIATIONS IN SURGICAL ACTIVITY RATE ²³				
Rate Per 10,000 Population (Age and Sex Adjusted)				
PROCEDURE	DISTRICTS		REGION	
	LOW	HIGH	LOW	HIGH
Hernias	10.0	20.0	8.5	14.5
Hemorrhoids	1.0	4.6	1.3	3.0
Prostatectomy	4.5	9.5	5.8	13.2
Cholecystectomy	7.0	11.0	5.7	9.7
Hysterectomy	7.5	15.0	18.1	28.7
Appendectomy	14.0	21.0	12.9	19.4
Tonsillectomy with and without adnoidectomy	7.5	27.5	14.0	25.0

Reviewing the effectiveness literature shows that not only do U.K. doctors "assault" young women with unnecessary D&C procedures, but they also "assault" young children with

20. *Id.* at 1 ("there is little or no information on the impact of health care services on the health of individual patients or the community at large").

21. See, e.g., John E. Wennberg, Jean L. Freeman & William J. Culp, *Are Hospital Services Rationed in New Haven or Over-Utilized in Boston?*, THE LANCET, May 23, 1987, at 1185-89 (1987).

22. See Angela Coulter, Anne Klassen, Ian Z. MacKenzie & Kim McPherson, *Diagnostic Dilation and Curettage: Is it Used Properly?*, 306 BRIT. MED. J. 236 (1993).

23. D. SANDERS, A. COULTER, & K. MCPHERSON, VARIATIONS IN HOSPITAL ADMISSION RATES: A REVIEW OF THE LITERATURE tbl. 3 (Project Paper 79, 1989).

hearing loss and "glue ears."²⁴ It has been concluded that for the majority of patients "watchful waiting" was the best treatment policy, since for many the hearing loss remedied itself.²⁵

Another study by the same group has shown that the efficacy and acceptability of two competing medications for the depression are not statistically different.²⁶ However, the latest treatment (selective serotonin reuptake inhibitors: SSRIs) is up to thirty times more expensive but is growing in use due to strong marketing.²⁷ The SSRIs, unlike their rivals the tricyclics, are not toxic in overdose, but the cost of using SSRI to minimize suicide risks may imply a value of life of hundreds of thousands of pounds.²⁸ This may be an inefficient use of resources because the most cost-effective treatment may be tricyclics.

TABLE 2.
PLAUSIBLE SOURCES OF VARIATION AT DIFFERENT
LEVELS OF AGGREGATION²⁹

Variation Between	Morbidity	Supply	Clinical	Demand
GPs	S	O	L	S
Districts	M	M	L	S
Regions	L	L	S	M
Countries	L	L	L	L
L = Large; M = Medium; S = Small; O = No effect relative to others in row				

24. Nick Freemantle et al., *The Treatment of Persistent Glue Ear*, EFFECTIVE HEALTH CARE, Bulletin No. 4, at A.1 at 2 (Centre for Health Economics (York) and School of Public Health (Leeds), 1992) ("Glue ear is a condition characterised (sic) by the presence of fluid (effusion) in the middle ear cavity. It is the most common cause of hearing impairment and reason for elective surgery in children.").

25. *Id.* I.2 at 10.

26. See Freemantle et al., *supra* note 24, at D.1 at 3-4. See also Fujian Song et al., *Selective Serontin Reuptake Inhibitors: Meta-analysis of Efficacy and Acceptability*, 1215 BRIT. MED. J. 683 (1993); N. Freemantle et al., *The Treatment of Depression in Primary Care*, EFFECTIVE HEALTH CARE, Bulletin No. 5 (Center for Health Economics (York) and School of Public Health (Leeds) 1993).

27. Freemantle et al., *supra* note 26; see also *id.* at D.12,13 at 6.

28. *Id.* at D.6 at 5.

29. Kim McPherson, *Why Do Variations Occur?*, in THE CHALLENGE OF MEDICAL PRACTICE VARIATIONS 29 (T.F. Anderson et al. eds., 1989).

The example of the shift in use from tricyclics to SSRIs based on the results of small studies and vigorous marketing by the industry demonstrates that clinical behavior can be changed quite rapidly with well-designed policies.³⁰ Often practice is very difficult to change as in the case of both glue ears and D&C interventions where these practices have been questioned before, but practices have been maintained. This outcome is due to the lack of attention to the issue of incentives.

In part, this is a function of the focus of the majority of the health care "actors" on spending and activity. It is unusual for clinicians in health systems to produce outcome data.³¹ Indeed, it can be seen that throughout history "externals" to clinical practice (non-physicians or radical doctors) have sought to collect this data.

Saddam Hussein's ancestors argued:

If a surgeon has made a deep incision in the body of a man with a lancet of bronze and saves the man's life, or has opened an abscess in the eye of a man and has saved his eye, he shall take 10 shekels of silver.

If the surgeon has made a deep incision in the body of a man with his lancet of bronze and so destroys the man's eye, they shall cut off his forehead.³²

A little more recently, the physician to the Prince of Wales wrote that:

In order, therefore, to procure this valuable collection, I humbly propose, first of all, that three or four persons should be employed in the hospitals (and that without any ways interfering with the gentlemen now concerned), to set down the cases of the patients there from day to day, candidly and judiciously, without any regard to private opinions or public systems, and at the year's end publish these facts just as they are, leaving every one to make the best use he can for himself.³³

Note that even in those days (over two-hundred-and-sixty years ago) "the gentlemen now concerned" had to be placated!

30. See *supra* notes 26-28 and accompanying text.

31. See KIND, *supra* note 19, at 1-5; Paul Kind, *Outcome Measurement Using Hospital Activity Data: Deaths Following Surgical Procedures*, 77 BRIT. J. SURGERY 1399 (1990).

32. STANLEY A. COOK, *THE LAWS OF MOSES AND THE CODE OF HAMMURABI* 246-47 (London 1903) (quoting §§ 215-218 of Hammurabi's Code).

33. FRANCES CLIFTON, *THE STATE OF PHYSIC, ANCIENT AND MODERN, BRIEFLY CONSIDERED: WITH A PLAN FOR THE IMPROVEMENT OF IT* (London, 1732).

By the nineteenth century, Thomas Wahley, the editor of *The Lancet* was arguing:

All public institutions must be compelled to keep case-books and registers, on a uniform plan. Annual abstracts of the results must be published. The annual medical report of cases must embrace hospitals, lying-in hospitals, dispensaries, lunatic asylums and prisons.³⁴

And this advocacy affected policy making. In 1844, the Lunacy Act required all public psychiatric hospitals to collect outcome data and distinguished "success" in three categories: dead, relieved and unrelieved.³⁵ This they did throughout the nineteenth century.³⁶

It was this classification which Florence Nightingale adopted. She argued:

I am fain to sum up with an urgent appeal for adopting this or some uniform system of publishing the statistical records of hospitals. There is a growing conviction that in all hospitals, even those which are best conducted, there is a great and unnecessary waste of life. . . .

In attempting to arrive at the truth, I have applied everywhere for information, but in scarcely an instance have I been able to obtain hospital records fit for any purpose of comparison. If they could be obtained, they would enable us to decide many other questions besides the ones alluded to. They would show subscribers how their money was being spent, what amount of good was really being done with it, or whether the money was doing mischief rather than good.³⁷

Despite this history of advocating the collection of outcome data, the practice is still unusual. Most NHS hospital activity systems aggregate discharges so that it is difficult to distinguish between "horizontal" (dead) and "vertical" (walking)

34. THE LANCET 650-51 (1841).

35. See generally Alison Patrucco Barnes, *The Randolph W. Thrower Symposium: Elder Law: Beyond Guardianship Reform: A Reevaluation of Autonomy and Beneficence for a System of Principled Decision-Making in Long Term Care*, 41 EMORY L J 633, 652 (1992). ("In the late 1800s, changes in society and treatment practices produced changes in the law. In England, the increasing use of institutional care led to passage of the Lunacy Act of 1890 which consolidated mental health legislation and attempted to limit the number of individuals subject to compulsory services by narrowing legal definitions and increasing legal barriers. For the first time, the treatment of the mentally ill was subject to legal constraints regardless of the need for property management.")

36. *Id.*

37. FLORENCE NIGHTINGALE, *SOME NOTES ON HOSPITALS* (3rd ed. 1863).

discharges!³⁸ Where data are available they show large variations in mortality³⁹ which have to be interpreted with care.

The major problem in determining treatment success is that there are few trial data to demonstrate effectiveness and cost-effectiveness. It is not unusual to select a therapeutic area (e.g., rehabilitation or mental health) and from a literature search identify less than a dozen studies in total.⁴⁰ All too little has changed in the period since 1972 when it was argued that the majority of therapies had no proven scientific basis.⁴¹ Victor Fuchs summarized the problem nicely arguing that ten percent of health care expenditure damaged patients' health, ten percent had no effect on health, and eighty percent of expenditure improved health.⁴² The problem is, as Fuchs noted, that no one knows which therapies lie in the ten and eighty percent categories.⁴³

The principles of resource allocation which can be derived from legislation are not translated into practice in the NHS. Clinical autonomy in the NHS remains very strong and the Thatcher health care reforms have yet to impact significantly on inefficient practice and inefficient practitioners.⁴⁴

3. Resource Allocation: The Physicians' Role

John Hampton, a cardiologist, wrote over ten years ago that clinical freedom was dead if it meant the freedom to allocate resources regardless of its impact on the patient's health.⁴⁵ However, the translation of this principle, that care should be demonstrably cost-effective, into practice is difficult despite the

38. KIND, *supra* note 19, at 4-5; see also *id.* at 7.

39. *Id.* at 27 ("Differences in mortality rate may be accounted for, at least in part, if allowance is made for qualitative or quantitative variations in resources provided by Health Authorities"). See also Kind, *supra* note 31.

40. See, e.g., MIKE McKENNA, ALAN MAYNARD & KEN WRIGHT, IS REHABILITATION COST EFFECTIVE? (University of York, Centre For Health Economics, Health Economics Consortium, Discussion Paper 101 1992); Owen O'Donnell, Alan Maynard, & Ken Wright, *Evaluating Mental Health Care: The Role of Economics*, 1 J. MENTAL H. 39 (1992).

41. A.L. COCHRANE, EFFECTIVENESS AND EFFICIENCY 9 (1972) (referring to proof in the forum of data from randomized controlled trials).

42. Victor R. Fuchs, *The "Rationing" of Medical Care*, 311 NEW ENG. J. MED. 1572, 1573 (1984).

43. *Id.*

44. See generally LETWIN, *supra* note 18, at 199-227.

45. John R. Hampton, *The End of Clinical Freedom*, 287 BRIT. MED. J. 1237, 1237-38 (1983).

articulate advocacy of leaders of medical opinion.⁴⁶ What are the prerequisites of the translation of the principles of resource allocation into efficient clinical practice?

The first step is to use the available literature to set standards or benchmarks of appropriate medical practice. This requires the "distilling" of the literature and its analysis by expert groups so as to identify indications for particular interventions. Some nice examples of this approach have been published by the Rand Corporation for therapeutic areas involving angioplasty, coronary artery bypass grafts, abdominal aortic aneurysm surgery and other areas.⁴⁷

The definition of appropriateness benchmarks facilitates the investigation of practice, *e.g.*, case notes and computer files can be interrogated to determine whether practice was appropriate. The results of this can be used to inform future practice via the processes of medical audit and management review. Such an investigative approach can identify inappropriate practice and avoidable deaths.⁴⁸

Appropriateness defined as effective practice may not be cost-effective practice. This can be illustrated with a simple example: an elderly person with muscle pain due to rheumatism can use drug X which gives five hours of pain relief or drug Y which gives ten hours of pain relief. Drug Y is clearly more effective. However, if drug X costs twenty-five pence per dose and drug Y costs 120 pence per dose, and neither has any side effects, drug X is preferred as it is the most cost-effective: five pence per hour of pain relief from drug X as opposed to twelve pence per hour of pain relief from drug Y.

46. See, *e.g.*, BRYAN JENNETT, HIGH TECHNOLOGY MEDICINE BENEFITS AND BURDENS 249-250 (1984).

47. L.H. HILBORNE ET AL., CORONARY ARTERY BYPASS GRAFT. A LITERATURE REVIEW AND RATINGS OF APPROPRIATENESS AND NECESSITY (1991); L.L. LEAPE ET AL., PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY. A LITERATURE REVIEW AND RATINGS OF APPROPRIATENESS AND NECESSITY (1991); D.J. BALLARD, ABDOMINAL AORTIC ANEURYSM SURGERY: A LITERATURE REVIEW AND RATINGS OF APPROPRIATENESS AND NECESSITY, SERIES JRA 04 (1992); D.B. MATCHER, CAROTID ENDARTERECTOMY. A LITERATURE REVIEW AND RATINGS OF APPROPRIATENESS AND NECESSITY, SERIES JRA 05 (1992).

48. See, *e.g.*, E.A. CAMPLING, H.B. DEVLIN, & J.N. LUNN, THE REPORT OF THE NATIONAL CONFIDENTIAL INQUIRY INTO PERIOPERATIVE DEATHS (London 1990) (providing a description of the confidential enquiry into perioperative deaths ("GEPOP") carried out by the Royal College of Surgeons and the Association of Anaesthetists).

While the number of economic evaluations in health care is increasing exponentially,⁴⁹ their quality is uneven.⁵⁰ As a consequence while effectiveness data are poor, the knowledge of cost-effectiveness is generally worse!

Yet, the physician is the key agent in resource allocation: it is she who determines access to care. In the NHS the general practitioner acts as the "gate keeper" to the hospital system, both for diagnostics and for treatment.⁵¹ The hospital consultant, and her firm of juniors, assess general practitioner referrals and offer advice and treatment as they judge appropriate.⁵² The waiting list, approaching one-million,⁵³ is used to ration access for non-emergency care, much of which is cost-effective. Emergency demands are met by open access and the "imperative of rescue" often leads to cost-ineffective interventions. Without guidelines of appropriateness, the clinician cannot resist patient and relatives' pressure to "do something" when a seventy-six-year-old man appears in casualty with a bleeding tumor at 3:00 a.m.! The dictum of Florence Nightingale from the 1860s not "to strive officiously" to keep the patient alive⁵⁴ tends to be ignored!

Such responses are complicated by the agency relationship. It is argued that there is an asymmetry of information in the health care market such that the doctor is the expert with superior ability to diagnose, treat and predict the outcome of disease. As a consequence of this, the consumer, after making her initial decision to enter the health care market, delegates decision making to the "expert." Thus, the primary agent on the supply side of the market becomes the agent who makes demand-side decisions. If those decisions were based on the predicted marginal productivity of the intervention (the margi-

49. M.E. Backhouse et al., *An Economic Evaluation Bibliography*, 1 HEALTH ECON. 4 (Supp. 1992).

50. Standards of "good practice" to appraise such evaluation can be seen in Alan Williams, *The Cost Benefits Approach*, 30 BRIT. MED. BULL. 252-56 (1974); see also MICHAEL F. DRUMMOND, GREG L. STODDART, & GEORGE W. TORRENCE, *METHODS FOR THE ECONOMIC EVALUATION OF HEALTH CARE PROGRAMES* (Oxford University Press 1987); Alan Maynard, *The Design of Future Cost-Benefit Studies*, 3 AM. HEALTH J. 761 (1990).

51. See LETWIN, *supra* note 18, at 214; see also *id.* at 217.

52. See KLEIN, *supra* note 1, at 44; see also *id.* at 113-114.

53. Dr. Brian Mawhinney Announces Latest Waiting Time Figures, U.K. DEP'T OF HEALTH (PRESS RELEASE) 94/218, May 6, 1994.

54. See NIGHTINGALE, *supra* note 37.

nal effect), this agency relationship would produce efficient treatment patterns. However, if the doctor pursues other targets, such as income enhancement empire building resource allocation will be inefficient.

Many markets such as law, real estate and vehicle repair have some degree of asymmetry in information. After this problem has been recognized by corporate attempts to control practices, these are often defeated by the self-interest of the regulated who capture it and use it to enhance their income and power: regulation favors the regulated.⁵⁵ These adverse effects can be dissipated by the production of knowledge to question practices and the creation of institutions (e.g., health care purchasers in managed care) to challenge the corporations. However, both the creation of such competition and its sustainment is costly and difficult.

The problems created by agency relationships may be compounded with providers having an increasing commercial interest in the inflation of demand for health care. It has been argued that doctors "are not, and should not be businessmen," but that market reforms are forcing them to behave in this way.⁵⁶ The American Medical Association recognizes that problems exist when physicians own the medical facilities for whom they recruit patients.⁵⁷ Its Council on Ethical and Judgment Affairs recommended no referrals by physicians to self-owned facilities and that they should invest in facilities only if no alternative funding is available.⁵⁸

The physicians' role in resource allocation is central. Typically, the physicians' scientific training is limited in terms of their capacity to question and evaluate existing practices. Medical schools tend to inculcate "facts," but place too little aware-

55. G. Stigler, *The Theory of Regulation*, BELL J. ECON. & MGMT SCI 1, 3-21 (1971).

56. Arnold S. Relhman, *What Market Values are Doing to Medicine*, THE ATLANTIC MONTHLY, March 1992, at 98-106.

57. See Dana Priest, *AMA Delegates Spar Over Self-Referral*, WASH POST, Dec. 7, 1992, at A11; Dana Priest, *AMA Decrees 'Self-Referral' is Unethical*, WASH POST, Dec. 9, 1992, at A1; cf. Brian McCormick, *AMA Reverses Self-Referral Stance*, 35 AM MED NEWS 1, Dec. 21, 1992, ("In addition, delegates rescinded a six-month-old policy that conflicted with council's ethical stance. That policy said self-referral arrangements were ethical so long as referring physicians disclosed their investment interests and patients were informed of alternative sites for receiving care.").

58. See Council on Ethical & Judgment Affairs, *Conflicts of Interest: Physician Ownership of Medical Facilities*, 267 JAMA 2366, 2368 (1992).

ness on the experimental nature of practice and the shallow knowledge upon which it is established. They are exposed to strong pressure to treat because, although aware of the social perspective (*i.e.*, opportunity costs exist for all decisions), they are trained to treat the individual patient in front of them, with all the pressures created by the imperative of rescue.

While the profession has regulated itself extensively, those processes are poorly informed by good science about costs and outcomes. All too often regulatory bodies such as the U.K. General Medical Council serves as a mechanism to discipline deviant practitioners who sleep with their patients, but do not address the issue of those physicians who are unusually successful in killing or disabling their patients! The U.K. Royal Colleges can, by withdrawing membership from practitioners, leave them unable to practice in the NHS, but this tends to be a discipline rarely used to control inefficient practitioners. Furthermore, any such discussions are conducted in secret, as was the CEPOD inquiry.⁵⁹

The "managers" of institutions controlling the practice of medicine are seeking to change the ways in which medical activity is conducted. The speed with which they are changing is slow but not inconsiderable. However, the "market" is requiring non-clinical managers to move more rapidly and there are risks both of duplication and conflict, particularly with regard to the acquisition and use of data about clinical practice. Such "competition" may be harmful. The naïve belief that markets are primarily driven by greed and self-interest was refuted by the alleged creator of such arguments, Adam Smith, over 200 years ago:

Those general rules of conduct when they have been fixed in our mind by habitual reflection, are of great use in correcting the misrepresentations of self-love concerning what is fit and proper to be done in our particular situation. . . . The regard of those general rules of conduct, is what is properly called a sense of duty, a principle of greatest consequence in human life, and the only principle by which the bulk of mankind are capable of directing their actions.⁶⁰

59. CAMPLING, DEVLIN & LUNN, *supra* note 48. See also KLEIN, *supra* note 1, at 114 n.25 (describing the U.K. Royal Colleges).

60. ADAM SMITH, *THE THEORY OF MORAL SENTIMENTS* 160-162 (D.D. Raphael & A.L. Macfie eds., Oxford 1976).

If conflict develops about the governance of medicine in the managed care/internal markets in the 1990s, arguments about quality may lead to a deterioration in the physician-patient relationship. Traditionally, patients have believed physicians "do good."⁶¹ If knowledge of practice variations, ineffective care and unproven practice spreads, and patients recognize the scope of physician-induced demand, there may be substantial effects on physician-patient relationships and resource allocation, notably a reduction in the placebo effect created by, *inter alia*, physician trust!⁶² Trust that is merited, that is earned by the use of truth for those who wish to know, can create shared decision-making which may improve the cost-effectiveness of medical practice.

For the "ideal" NHS to work efficiently, priorities must be determined by where the greatest improvements in caring and curing can be produced at the margin. Producers will judge the success of the NHS, in this ideal world, by their ability to produce cost-effective care.⁶³ To achieve this ideal, the knowledge base needs to be increased and the results of such evaluative work used by professional bodies, purchasers and providers to create a cost-effective health care system.

CONCLUSION

The arguments in this article are in the utilitarian tradition favored by many economists. Implicit in these arguments has been an acceptance of the principle of justice of "equality of treatment for those who are in all relevant respects equal"⁶⁴ and the interpretation of need for treatment as the capacity of the patient to benefit at the margin.

The consequence of this is that those with limited capacity to benefit will be denied care. This may have unfortunate implications for groups who, for reasons such as genetic endowment, income, age and education, may have limited capacity to

61. See Victor R. Fuchs, *The Counterrevolution in Health Care Financing*, 316 NEW ENG. J. MED. 1154, 1155 (1987) ("Physicians have traditionally idealized the ethic of duty to their patients, and patients have derived considerable comfort from believing that physicians hold to this ethic").

62. See PETER SKRABANEK & JAMES MCCORMICK, FOLLIES AND FALLACIES IN MEDICINE ch. 1 (1989).

63. MAYNARD & WILLIAMS, *supra* note 5, at 5.

64. J.M. Stanley, *Developing Guidelines for Decisions to Forego Life Prolonging Medical Treatment*, J. MED. ETHICS, Supp. 1992, at 18.

benefit. If society decides that it wishes to redistribute care to these needy groups, the opportunity costs of doing so will be apparent and this will enhance public debate and the accountability of policy makers.

An important problem in the discussion of resource allocation rules is, of course, the divergence between the principles which emerge after much debate, and their implementation. In the NHS, the rules implicit in legislation nearly fifty years ago still have little impact on decision making and market transactions. In the NHS there are regular "redisorganizations" to achieve the Holy Grail of efficiency, equity and justice, but all too often rhetoric dominates substance just as in the time of the Emperor Nero:

We trained very hard, but it seemed that every time we were beginning to form up into teams, we would be reorganized. I was to learn later in life that we tend to meet any new situation by reorganizing, and a wonderful method it can be for creating the illusion of progress, while producing confusion, inefficiency and demoralization.⁶⁵

65. Caius Petronius, AD 66, quoted in Kevin Townsend, *New Zealand: Study Finds "Illusion of Progress"* — *Health*, N.Z. HERALD, Feb. 11, 1993.

