Ethics, ideology and rationing in the NHS

Since the beginnings of the welfare state, fifty odd years ago, there have been vast changes both in the world and in ideology. Its philosophy was that everyone in society had – or in due course would have – needs which it was the duty of the state to meet, either directly or through local authorities. This duty was a moral duty and also a matter of a conscious political policy, namely a socialist policy. Socialism, we were told, was about equality; and the welfare state set about to meet the needs of all people equally. Though it was not forbidden that people who could and who wished to do so should pay for private medical care, private education, private pension arrangements or private services in their homes, welfarism demanded that nobody had to make private contractual arrangements. That people had educational, medical or service needs constituted an imperative for the state itself and therefore an entitlement for everyone to have that need met.

This was the philosophy that lay behind the Beveridge Report on Social Insurance and Allied Services, published in 1942, which appealed so enormously to those of us who were voting in our first general election in 1945. We were prepared for high taxation and high employees' contributions in order that this universal benefit should be brought about. It promised idealism as well as personal advantage, and very exciting it was.

In establishing what should be considered a social need that must be met, Beveridge recognised that the concept of 'need' would change over time and that this would entail an ever-increasing expenditure. There was, he argued, a social element in this concept. New developments in society would be likely to increase demand, and what had once seemed sufficient would come to seem insufficient. He did not foresee – but would not have been unduly surprised by – the new 'need' to own a television set or a refrigerator, nor the new kinds of need brought into existence by increasing numbers of single-parent families.

In the case of the National Health Service, there was some difference of opinion. The optimists believed that equal access to health care, including preventive medicine, would mean that the population as a whole became healthier and would call on health services less frequently. The same optimists believed that advances in medicine and pharmacology would make medicine more efficient and each treatment less drawn out. Realists, however, recognised that as more cures became possible, whether by surgery or drugs, more and more would be expected. Fewer children would die, epidemics would be contained, some diseases virtually eliminated and so, inevitably, the population as a whole would age. Through no fault of their own, the old were recognised as inveterate consumers of health care and also of social care.

It fairly soon became clear that demands on social services and on the health service were increasing, as also were expectations, but it was assumed that, somehow or other, people's needs would be met. In the case of the health service, the belief that needs must be met was reinforced by the age-old morality of medicine: that a doctor must do everything in his or her power for the well-being of the patient, whose good is paramount. This morality has been the glory and, indeed, the heroic romance of medicine. It forms the background of our present troubles, just as surely as does the philosophy of welfarism.

From welfarism to Keith Joseph

Our present crisis in the National Health Service is not the fault of any government or local authority. It should be seen rather as inherent in welfarism, to which Conservatives as well as Labour were committed for many years. If a government is committed to meeting people's needs, it is inevitably faced with escalating costs sooner or later. The question is only how it is going to deal with this and with what degree of honesty it is going to face the public with the proposition that resources must be allocated according to some plan – that they must, in short, be rationed.

Under Mrs Thatcher the Conservatives took the bold line of denigrating welfarism on theoretical-philosophical grounds. This was a radical attempt to change a way of thinking that had, in more than thirty years, become part of British thought and indeed, part of British pride, when they compared themselves with North Americans. The new philosophy of conservatism can be attributed – if to any one man – to Sir Keith Joseph. The welfare state came to be called the Nanny State. What is wrong with nanny is that she knows best. She determines what is good for her charges and imposes it on them, whether they think it is good for them or not. Grown-ups, it was implied, do not require and should not have a nanny. If they do, they become dependent on her. They lose the power to make up their own minds. They get out of the way of making choices and doing things for themselves; for the one thing that those who are in nanny's power have none of is freedom – freedom to choose their own way of life, even if that way leads them to destruction. By implication, those who criticise the Nanny State elevate 'choice' as the highest good; and so it was for the Tories, throughout the eighties and nineties. People should be released from the state's dictates and become free to choose to take out their own

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insurance policies, to buy their council houses, to opt their
schools out of the power of local authorities and make the
school what they wanted; and doctors, as fundholders, should be free to choose where it was best to send their patients if they had to go to hospital. The idea of needs that must be met by the state almost disappeared in the eighties and nineties.

This was the background against which the National Health Service was born and then developed. Whether or not we had followed Mrs Thatcher's way of thinking and talking, it is certain that the inevitable demands on the health services would by now have far outstripped the available resources. It could be argued that it was at least brave of the Tories to try to invent a wholly new philosophy to replace that of meeting needs rather than to pretend, as the opposition were free to do, that the ideals of the welfare state could be preserved and that they were being eroded only by deliberate Tory malice, as engagements in the class war. To be able to keep up this pretence was part of the privileged position of an opposition party which, at least until the imminence of a general election, needed no detailed strategies.

Where are we now?

Reality is now breaking in. Five years ago it would have been impossible to talk openly about rationing or even about priorities, a more polite word for the same thing. The medical profession and the social services professionals have long known, however, that there are not enough resources and that, among themselves, they must endlessly discuss these problems.

The public has begun to face these facts much more recently and even now finds it hard to accept them. There was widespread outrage when the Cambridge Health Authority, a few years ago, said that they could not pay for a third transplant attempt for a child, known as Child B, because the cost, weighed against the chances of a successful outcome, did not justify it. The fact that a child was involved made it particularly emotive. Immediately, the man who announced the decision was described as a murderer. He later published a calm and brave article demanding that such decisions should be made openly and seen for what they are – decisions of priorities, in which probability (that is of outcome) must be brought in as a factor as well as the matter of needless suffering for a child.

There are two different kinds of difficulty inherent in open discussions of this nature. The first concerns the notion of probability itself. We all, even those who are statisticians, find it very difficult to marry the numerical probability that something will occur with the everyday sense of the word. If a doctor tries to reassure a nervous mother about a whooping cough inoculation by citing statistics of how few children suffer harm from it, he will most likely fail, because she wants to know whether her baby is likely to be the one per x thousands of babies who dies and this he cannot tell her. So when it was stated that the probability of the third transplant succeeding was very low, this could be interpreted as just a numerical probability, almost irrelevant to the real chance that this particular child would survive.

The other difficulty is yet more intractable and more general. By long and honourable tradition, a doctor has to do what is best for a patient – meaning each individual patient, here and now. But a doctor also has a duty to the health service and thus to society as a whole. How can these two duties be reconciled or even compared when they seem to conflict? Suppose the case of a neonate in intensive care on a life support machine, badly malformed and with the likelihood of only a short life of low quality if he survives at all. The parents, let us say, have already refused an abortion on principle when it was shown during pregnancy that the child would be severely disabled. They believe that all human life is sacred, before and after birth, and they believe in the efficacy of prayer. The doctor knows it is his duty to persuade the parents to allow the baby to die. If the baby survives he will also constitute a vast expense to the health service. Meanwhile, there is an acute shortage of beds in intensive care and other babies in need of them.

With tact and luck the doctor may persuade the parents that further treatment is futile, and they may allow the machine to be turned off. What he cannot say to them, though it may be prominent in his mind, is that further treatment is also an appalling waste of resources. They would, given their beliefs, interpret this as saying that you can kill a baby for the sake of saving money. And this interpretation, if true, would be intolerable, the end of all compassion, and a plain dereliction of the doctor's professional commitment to his patient. Moreover, the case would be a peg on which to hang the slippery slope argument, a form of argument that has an irresistible appeal to people's imagination. If limited resources, they would say, can be invoked to justify the withdrawal of treatment in this case, where will it end? Will it end with the killing of all disabled people, on the grounds that their treatment constitutes a waste of money?

The slippery slope

The slippery slope argument must be taken seriously only because it is so commonly invoked. But the answer to the question (will allowing the baby to die lead to the slaughter of all disabled people?) is obviously that it need not lead in that direction at all. For the story of the neonate is a particular story and if, taking all the circumstances into account, the parents agree that the baby shall die, the outcome is a particular outcome. The doctor may be profoundly relieved if what he thinks ought to happen in the circumstances can be allowed to happen – and may also be relieved on financial and resource grounds. But note two things: first, if he could save the baby with the prospect of having a reasonable life ahead of him he would; and secondly, he can do nothing without the agreement of the parents. In this sort of case parental consent, combined with the professional
commitment of the doctor to a patient who has a reasonable hope, must together constitute the block on the slippery slope. Similarly, the decision to stop treating a patient with irreversible coma can hardly be depicted as the road to a widespread, cost-saving euthanasia.

If these arguments are accepted, we are not about to rush into a programme of mass destruction. We will be prevented from doing so by our humanity and doctors' professionalism. To say this is, of course, to express a faith in humanity that may seem naive. I firmly believe, however, that in the case of the practice of medicine and our responsibility of one for another in society, that faith is justified.

The slippery slope argument, so often used to frighten people about an imagined future, assumes the worst of humanity. Give them an inch and they will take an ell. It also assumes that all cases are alike and that nobody is capable of making a decision that distinguishes things that differ from each other. It is probably a lurking slippery slope argument that makes people so terribly afraid of making medical decisions on grounds of expense of treatment. This is why it is so difficult to say to a patient: 'There is something we could try, but I'm afraid we can't afford it'. If a doctor can say that and honestly say 'and I doubt if it would work', then people who use the National Health Service may gradually come to find it acceptable. The more we talk openly about rationing, the more they will come to accept that there are financial limitations. Although we are all selfish when we, or more especially our families, are ill, we may have to learn to temper our selfishness by some thought for the society of which we are part.

Rationing? Or more efficiency?

To discuss rationing in such general terms may, perhaps, give the impression that there is a uniform way, capable of being codified, to establish what is or is not cost-effective, whether in medical or social care. This is a fallacy. There may be generalisations that can be drawn from experience, but it would be disastrous to have a rigorous code of priorities that must be adhered to regardless of particular personal or local circumstances. We shall never eliminate differences between parts of the country in the priorities set, nor should we try to. Both medical and social services – and especially the areas where they overlap and interlock – depend on people getting on together, working out strategies, sharing bright ideas. A tremendous lot would be lost if these alliances were lost through a passion for uniformity. Again, good and innovative doctors attract others around them and special expertise is a gradual and a not entirely planned phenomenon. Where there is local expertise, a requirement for uniformity could damage both existing services and service developments. In addition, if there are decisions of principle to be made – with regard, for instance, to what kind of person should have a particular type of surgery or what kind of person should have sheltered housing – there must be some flexibility in the decisions made by people who know what is needed, what is possible at a local level, and who have the particular case in mind. The medical, social and paramedical professions cannot escape the need to make value judgements and to assess the probable quality of people's lives. Such value judgements must lie at the heart of the decision as to whether services should be provided or a procedure carried out.

Politicians are sometimes prone to speak as though if only there were greater efficiency and less waste in both medicine and social services, there would be no need to have rationing of services at all. I hope that I have said enough to suggest that in some sense or other rationing is essential and has been known to be so for years – though not to the public at large. That is not to deny that, perhaps especially in the social services, greater efficiency and less waste are also crucial and that, lamentably, ever stricter ways are needed for weeding out scroungers, fraudsters, and those who would exploit the services. For medicine, this analysis must entail better ways of measuring cost-effectiveness.

Cost-effectiveness is the stuff of welfare economics, but such measurements are bound to remain crude. Despite current efforts, what is often held up as the goal is that there should be as many as possible activities for the least amount of money. It is, however, not activities but outcomes that need to be evaluated against money spent. Transactions alone give no indication as to whether they are successful or unsuccessful, and the number of hospital attendances is of no interest if no effort is made to judge whether improvements in the quality of people's lives can be put alongside expenditure. One might be able to judge how cost-effective hip replacements are, but it is more difficult to judge how cost-effective it is to keep the aged in their own homes until the end of their lives. People's values differ, and it is hard to put a price on living at home, however precariously, as against living in an institution. Until better measures are devised, there are limits to the circumstances in which we can apply valid criteria of cost-effectiveness even if, in the meantime, we are bound to press for more economies.

Conclusion

In conclusion, we have reached a stage when, without necessarily giving up the good aspects of welfarism – that everyone should be treated equally – we may have to acknowledge that some things cannot be afforded and that, therefore, private as well as public money may have to be expended on health care provision, with the means test (by a more acceptable name) becoming once again an accepted phenomenon. Alongside this, we must learn not to throw up our hands in horror when something is described as not being cost-effective. However reluctantly, it seems that we must adopt something more like the Keith Joseph than the Beveridge philosophy.

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