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Background paper

Social values in health and social care

Anthony J Culyer

Chair: **Kate Barker**

The King's Fund
11-13 Cavendish Square
London W1G 0AN
Tel 020 7307 2400

Registered charity: 1126980

www.kingsfund.org.uk

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Anthony J Culyer

Ontario Research Chair in Health Policy and System Design, University of Toronto and Professor of Economics, University of York

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1 Introduction

Almost all decisions about the design of health and social care systems, as well as those to do with their continuing operation, are deeply imbued with social values; that is, value judgements about what is good for society. They are not necessarily value judgements by or of society. But, regardless of source, they are always judgements of value *about* society. Social value judgements are not, however, the only kind of value judgement involved in system design and operation. There are others, especially in health and social care, which relate, for example, to the quality of the evidence used to support particular ways of doing things: was the science *good* science? Can the data be *trusted*? Is the thing we use to measure health and its value, or changes in that value, a truly valid measure of it? Other judgements may relate only indirectly to social values and focus instead on predicting factual consequences, addressing questions like 'what is likely to happen if...?' They might relate to the behavioural responses people have to system design or changes in it: is the co-payment for drugs low enough for the needy not to be deterred from taking their prescriptions? Can fee-for-service payments to physicians generate the desired levels of voluntary immunisations? Do local commissioning arrangements truly embody the health and socially relevant characteristics of the local populations they serve? Yet other judgements are required if one is, say, concerned about the quality of a doctor's professional performance, or the balance to be struck between using manufacturers' confidential evidence about clinical evidence and maintaining public confidence through transparency of National Institute of Health and Care Excellence's procedures. The *social* value judgements, however, are the set of values that really underpin all others. Unless the system and the way it works somehow succeeds in embodying these most fundamental values, then it fails in a very fundamental sense even if it succeeds in its science, data, measures of performance and political success. This paper focuses on social value judgements.

There are many aspects to social values.

They are *social*. That is, they relate to groups of people and the relationships between them.

They can relate both to processes (how things are done) and to outcomes (the consequences that flow from what is done). This is a distinction between ends and means. In health and social care, social value judgements are nearly always entwined in the ends sought, such as population health gain and the elimination of avoidable inequalities of health. Means, however, are usually to be judged in terms of their effectiveness in enabling ends to be realised. Taking one's medicine is a means to an end (better health). In general, means are justified only by ends. After all, if an end cannot justify a means, what can? That is not to say that an end can justify *any* means: plainly some means are so awful (say, the torture of children) that no end could possibly justify them, and some ends (say, the extermination of unpopular people) so awful that no means could possibly be justified in achieving them. Sometimes ends and means can become confused. For example, health care is a means to the end of better health. But better health is also a means to a more ultimate end: the flourishing life. Sometimes it is not clear that the means is *only* a means. Health care and social care may

indeed be means to the end of better and fairer health and fuller lives but one needs to ask if their effectiveness in achieving those ends (and probably others too) is all that matters. If it is, then the critical test health and social care interventions need to pass is that of *effectiveness* or, as will be seen, cost-effectiveness. One needs to discover and evaluate the evidence for one health or social care intervention being more instrumental than another in promoting the ends we seek. But if health and social care are regarded as inherently good things as well as being instrumental for more ultimate good things, then such tests are not enough: we need also to evaluate the interventions not merely as means but as experiences in their own right. Similarly, is the integration of health and social care a means to the ends of 'better health more fairly distributed', or something that is inherently desirable? These are matters on which a view needs to be taken since the kind of evaluation needed will differ accordingly.

Being treated with kindness and dignity is a social value judgement about the processes of health and social care. Treating employees with fair terms of service and adequate wages and salaries is a social value judgement about process. These may or may not be as important as the consequences for health and quality of life that they generate but they are surely there to be taken into account for their potential to improve or diminish the quality of people's lives.

Valuing a health gain for a very deprived person more than the same gain to a person not at all deprived is a social value about the *outcome* of a process of care. So is valuing an extension of life over an increase in the quality of life with no extension.

Social values have ethical status. What I mean by this is that a social value is something suggesting that we *ought to act* in a way reflecting that value. Values are moral principles and ought to be followed, if they can be. There are lots of such values and they may well conflict. For example, the common value that available resources in health and social care should be used to have the greatest possible impact on population health may conflict with the value that the geographical distribution of those resources should be equal. Some argue that an important social value is to seek as far as possible an equal distribution, not of resources, but of *health* in the population. However, that might involve an unequal distribution of resources in order to make sure that those least healthy, who nonetheless have capacities to benefit from health and social care, get an appropriately greater share. We therefore need to ask what equalities and inequalities matter.

Not all values can be fully respected or followed, simply because they are very demanding. That is not necessarily a bad thing. It is arguably at least as important to be able to measure one's shortfalls from perfection as it is to struggle to attain it. To achieve the perfection of a Christ or the Prophet or the Buddha may be beyond ordinary mortals but that need not devalue the merit of having the standard to aim at. In health and social care it is important to know what one ideally aims for, but it is also important not to let the perfect become the enemy of the merely good when it comes to performance. Not all surgeons are equally skilled. Not all social workers are equally up-to-date with the evidence on most effective child protection. Variation is inevitable and can co-exist with the highest standards so long as reasonable ranges of acceptable performance are laid down.

Social value judgements are often controversial. Some view health care as a set of services that is there to be bought as one wishes, as a part of the rewards

structure of society. Others regard these services as a right, with entitlement to receive dependent only on citizenship, or residence, or being a taxpayer, or simply 'being'. Even the act of choosing between these four possible categories of entitlement might be controversial.

Judging the effectiveness of health and social care as a means of improving health outcomes is at the core of much modern health and social care policy. In addressing the question 'should the NHS make treatment X available?' one might reasonably demand to know whether X 'works' and, if it does, whether it works better or worse than feasible alternatives and, if better than the alternatives, whether it is 'worth' including on the list of available procedures: 'is it cost-effective?' – an important topic to be discussed further. Answering this question properly evidently needs more than mere social value judgements. We need to know not just whether it 'works' but how good the evidence is, what groups of people it works for, how well it works for them and for subgroups within the wider group, what contribution it might make to reducing avoidable health and social inequalities, and what it would cost.

Cost is also a value and no mere matter of accountancy. If we introduce a new health care procedure, the cost will have to come out of expenditure elsewhere in the NHS – unless there is a concurrent increase in the NHS budget. But less expenditure elsewhere will normally imply reduction of service elsewhere and a consequential health *loss*. The true cost of getting more care (and hence health) in one area of activity is therefore the minimum necessary loss of care (and loss of health) elsewhere. This is the important notion of *opportunity cost*.

My purpose in this paper is not to provide answers, though readers may be able to detect some that are implicit in the way the questions are posed. I do not intend to reveal my own social value judgements. Instead I shall try to outline some of the main value judgemental issues that arise in health and social care and indicate what some people have had to say about them. The idea is that this may aid discussion and greater explicitness. I must admit to one expressed value of my own – that explicitness is nearly always preferable to implicitness. I think it leads to better decisions, but I also think it's the right thing to do (it is a means *and* an end).

The main way of approaching the issues will be to present them as conflicts. This sharpens them through contrasts and more or less forces the reader to take sides. I have chosen the topics that seem to me to have been characteristic of the post-war history of discussions about health and social care policy in the UK. This gives the following something of the appearance of a lexicon, with the topics roughly ordered from top level down. In a short space the treatment cannot be encyclopaedic but I hope readers will at least find it helpful. The difficult task of *applying* the various concepts and ideas is left largely to the reader, space being given only occasionally and briefly to illustrations.

2 Liberalism versus libertarianism

In both health and social care, a 'top-level' debate about values has concerned the role of markets and the limits of individualism or collectivism. These arguments usually have their roots in the classic clash between liberalism (including liberal socialism) and libertarianism.

In contrast to the informal, mostly north American, usage of 'liberal' as any more or less left-leaning political view, liberalism is the doctrine that seeks to combine two values that themselves often clash: respect for individual liberty (liberty of thought, speech, religion, and political action; freedom from government interference with privacy, personal life, and the exercise of individual inclination) and maintaining a democratic society controlled by its citizens and serving their needs, in which inequalities of political and economic power and social position are not excessive but moderated through progressive taxation, public provision of a social minimum, and the insulation of political affairs from the excessive influence of private wealth and social status.

Libertarianism is a doctrine that exalts the claim of individual freedom of action, and asks why any state power at all should be permitted – even the interference represented by progressive taxation and public provision of health care, education, and a minimum standard of living.

While this paper will not contain any discussion of these two philosophies at the general level, it will at various points touch upon issues whose resolution may involve violation of one or more of the tenets of either; see Nagel (1975) on the two ideologies.

3 The market versus the state

A western liberal state typically relies on markets to produce and distribute goods and services. For the market mechanism to work well a number of quite demanding conditions need to be satisfied. The same goes for systems using more centralised systems of planning and management and with less reliance on exchangeable private property rights. So no system is perfect. The list of reasons why the market may fail is, however, a good point of departure for considering how far health, welfare and the caring services that support them require special forms of organisation, ownership and finance (Culyer 2012e).

Part of the case for the NHS is that health is 'special'. It may be helpful to think of two approaches within the 'health is special' view (in contrast to the view that in all essentials it is no different from any other good or service). These are the 'caring externality' approach and the 'primary good' approach. The caring externality approach starts from the proposition that large numbers of people in the community *care* about the health of fellow citizens (or, simply and more generally, fellow humans). They prefer it when not only they themselves are well and free from sickness and disability and have a good expectation of life but also when their friends, neighbours, compatriots are well, etc. The first thing to note about this view is that it is based on preferences, so one needs to ask whether mere preferences are a strong enough base on which to erect a case for the NHS. Second, having a preference for something either for oneself or for someone else generally implies having a willingness to pay for it, so the caring externality approach implies that one is willing to pay not only for one's own better health but also for the better health of others. One may be unlikely to place as high a value upon it as upon one's own health, or that of one's nearest and dearest, but some positive value is implied. From this, it is a relatively short step to concluding that health services are probably sensibly provided at subsidised prices, to encourage their use, and that access to them should be made as easy as practicable so that diagnoses can be made and a need for treatment assessed. It may also be thought to follow that health care ought to be provided, at least in part, either by charitable organisations (as it was in the west for centuries by the churches) or by the state.

The primary good approach does not depend on preferences. Instead it is based on a view that health is so fundamental a human attribute for the attainment of a flourishing life, and its absence so potentially destructive of the flourishing life, that it has a special moral status among other primary goods, like access to the law in defence of one's rights, and rights to minimal levels of education. Having a flourishing life becomes the ultimate yardstick for human welfare. The fact that more health may also be preferred to less is, on this view, of lesser significance. Instead, health is usually needed if one is to live a fulfilling life. So, if health and social care are needed for health, and health (among other things) is needed for the flourishing life, then health and social care are also needed for people to have flourishing lives. Of course, it is easy to point to individuals with devastatingly poor health who somehow triumph over adversity and achieve remarkable things and appear to be extremely happy people. But these are probably rather special people. Others may be crushed by ill health. And triumphing over adversity is surely a rare accomplishment worthy of unusual admiration. It is in this sense that health is a primary characteristic and health and social care are primary goods; two related (but not at all the only) means of delivering that health.

Something that differentiates these two views – the caring externality and the primary good approaches – is that the second tends to be more egalitarian. You might find it as hard to justify large but avoidable differences in people’s possession of a primary good like health as it would be to justify large but avoidable differences in their flourishing as individuals. If so you should seek ways of allocating health and social care resources so that they not only have effective impact on health and welfare but also tend to reduce avoidable inequalities in health.

Another implication of both is that a particular focus of policy attention becomes population health. An over-simplified characterisation might be that the correct policy on these views becomes one of (a) maximising population health (out of the resources allocated to health and social care) and (b) ensuring that avoidable inequalities in health are minimised.

A very important implication, again of both views, is that the health and social care services have this character of being ‘special’ *only if they are effective*. That is, only if they work as a means to the end of better and fairer health. Ineffective health and social care does not benefit people’s health, so how can its public subsidy be justified? Likewise ineffective health and social care will contribute nothing to fairer distributions of health in the community (Culyer 2012b).

The question immediately arises: is it possible to separate health and social care interventions that work from those that don’t? The answer is not only ‘yes’, but we also have an institution in the NHS (National Institute for Health and Care Excellence – NICE) whose principal task is to assemble the relevant evidence and make recommendations to the NHS about treatments that work and the patients for whom they work best.

Discovering what works and what does not, what does harm, and what works but not sufficiently well to be preferred over other treatments that work better, requires research and the gathering of reliable information. It also requires that the professionals who prescribe health or social care treatments can interpret the evidence and that the manufacturers of medicines and clinical equipment test them for both safety and effectiveness and share the resultant information (even when it is commercially unfavourable to them). The history of health care, both before the NHS was founded and since, is littered with examples of harmful, ineffective or insufficiently effective interventions. A well-known example of a treatment that did more harm than good was the sleeping pill thalidomide. Introduced in the NHS towards the end of the 1950s, thousands of deformed babies worldwide were the innocent victims of an insufficiently researched drug. Diethylstilboestrol (DES) was once a popular treatment for the prevention of miscarriages and stillbirths. If doctors had known how to distinguish the reliable research available in the 1950s from poorer research, far fewer of them would have prescribed DES, which carried unacceptable risks of cancer and damage to women’s reproductive systems. Of course, in cases like these there was no harmful *intent* but the consequences were nonetheless harmful.

The risk of serious harm is not confined to drug treatments. Some implants and prostheses are poorly researched and have harmful consequences, even preventive measures like screening can harm, in cases where there is a high frequency of false positives or false negatives: the former cause unnecessary alarm and further diagnostics and the latter reassure doctors and patients alike that there is nothing wrong when in fact treatable disease is present.

Even an intervention as 'low-tech' as how best to put baby to bed has been proven dangerous. Dr Benjamin Spock's book *Baby and child care*, was the standard guide to parenting for many years. From 1956 on it contained the following apparently logical advice to thousands of mothers: 'There are two disadvantages to a baby's sleeping on his back. If he vomits, he's more likely to choke on the vomitus. Also he tends to keep his head turned towards the same side, this may flatten the side of his head... I think it is preferable to accustom a baby to sleeping on his stomach from the start' (cited in Chalmers 2003, p 23). As Iain Chalmers has commented, reflecting on his own early days as a medical practitioner, 'No doubt like millions of Spock's other readers, I passed on this apparently rational, theory-based and authoritative advice. We now know from the dramatic effects of the "Back to Sleep" campaigns in several countries that the practice promulgated by well-intentioned experts like Spock led to tens of thousands of avoidable sudden infant deaths' (Chalmers 2005, p 229). Many other examples can be found in Evans *et al* (2007).

The message is that NHS expenditure on harmful interventions ought to be stopped or, preferably, prevented through adequate research, knowledge, translation and professional uptake. but so ought public expenditure on ineffective and unproven interventions. Disinvestment in harmful, unproven, ineffective and cost-ineffective procedures is at least as important as not investing in such procedures in the first place. But they are tasks, one must add, that are more easily stated than implemented (Pearson and Littlejohns 2007). Even effective interventions ought not to be provided publicly if other interventions are at least as effective or more cost-effective in the sense that for the same cost better outcomes could be obtained by using alternative procedures. Sorting the wheat from the chaff among interventions is what *health technology assessment* (HTA) is about. Helping health professionals of all kinds to use only the most effective procedures is what *professional guidelines* are about. These methods are now well established in the NHS, where NICE has a key role in providing both, but currently sadly lacking in social services.

But, if you do not subscribe to either the caring externality or the primary good approaches, and especially if you tend to the libertarian end of the political spectrum, then not only will you regard NICE and its purposes as essentially mischievous but you will reject in their entirety both arguments for state intervention of the sort that eases access and promotes equality. The market will do. Caveat emptor (buyer beware!). This is a 'top-level' choice about 'top-level' social values.

Hidden in this account is the presumption that it is indeed an aspiration to maximise the impact of resources on health. There are ample ministerial pronouncements that seem to imply that this is a major purpose of the NHS but it ought not to be taken for granted.

4 Public versus private insurance

An initial concern that the NHS was founded to address was the cost of accessing health care: before the Second World War it was for many people prohibitive, while those who could afford it could still ensnare themselves with immense and catastrophic expenditures. With the tremendous developments in medicine since then, the potential personal costs of care have risen astronomically. It is not unusual, for example, even in the wealthy US, for families who are without insurance to fail to receive the care they need or for them to have to sell or remortgage their home in order to be able to pay for the care they have received (eg, Ayanian *et al* 2000). Health care expenses are (save for known pre-existing conditions) insurable, however, and the opportunities for doing so are very much greater than they were between the two world wars. The question still arises, therefore, as to how best to organise insurance against medical costs.

Modern insurance markets are sophisticated and offer many choices of coverage, premium payments and 'co-payments' (further contributions by the premium payer when services are used). Insurance companies also have to check for fraudulent claims (both from their insured clients and from health care agencies who may overcharge) and they will incur advertising and other marketing costs. Public (social) insurance via contributions or taxation also has pros and cons. Whatever the system, however, four apparently technical but actually quite key matters warrant special attention: the contents of the insured bundle, the socio-economic gradient, moral hazard, and adverse selection.

The insured bundle

In a market, the services to which one is entitled and the conditions attaching to their receipt are a 'bundle' offered by insurance companies. In practice, bundles vary widely and there are major issues of comprehensibility for many clients. They are also often offered as a benefit of employment, with the consequence that becoming unemployed may lose a family its health insurance cover. Most high-income countries have safety net schemes of varying degrees of completeness, like Medicaid in the US (a programme for low-income residents addressed particularly to families with children, pregnant women, children, the aged, the blind and the disabled) and Medicare (a programme mainly for older people) that offer care for a partial bundle with low or zero co-payments.

The issue of social value is whether there ought to be a generally agreed bundle (of effective services), that is available to all, and that is explicit and accessed on terms that are consistent with the underlying values of the health care system. How that matter is resolved will depend on where one is on the liberal/libertarian spectrum among other things, including affordability and adequate availability of the appropriate clinical skills in appropriate and accessible places.

The socio-economic gradient

In general, the richer one is, or the higher one's socio-economic class, the longer one may expect to live. In addition, the richer one is the better one's health status is at all stages of that longer life. This is the 'gradient'. It was first systematically identified in the Whitehall studies but has been replicated

many times over in Britain and abroad (see Marmot *et al* 1991). It has many implications of which two are especially relevant in the context of social values. First, it is not just 'us and them' – the rich and the poor. The characteristic of a gradient is that wherever you are in the socio-economic scale, a movement up will enhance your health and expectation of life and a movement down will do the reverse. Second, insurance premiums are usually set in such a way that the higher your risk and the costlier your expected treatment, the higher your premium. The gradient therefore implies that the poorest people face the highest premiums and the richest the lowest premiums, and so on throughout the gradient. Whether this is of concern will depend upon where you are in the liberal/libertarian spectrum. If it is of concern, then means need to be found of reducing both the unequal burden of premium payments and the unequal access to care.

Moral hazard

Insurance has the effect of reducing the price of care for those insured. In the extreme, the price is reduced to zero. Two things follow. First the incentive is reduced to avoid the need for health and social care at least in respect of the financial burden it would have created. This is called *ex ante* (based on forecasts) moral hazard. Second, as the price of anything, including care, falls, more is demanded. In particular, more than is really needed may be demanded, and it is likely also to be supplied by hospitals and other providers, so long as they know they will be reimbursed by the insurer. This is called *ex post* (based on results) moral hazard. These issues arise both in public and private insurance. The main question involving social values relates to the methods used to control both kinds of moral hazard: for example, no-claims bonuses or health education, preventive programmes and public health programmes to control *ex ante* moral hazard; co-payments or rationing by needs and waiting times to control *ex post* moral hazard.

Adverse selection

Perfect risk discrimination by insurers whereby the smallest differential risk or cost of treatment between individuals is reflected in the premium, is rarely possible. Instead, they tend to set their premiums in relation to the experience of groups defined by, for example, age, gender, lifestyle, family size. If members of groups have different probabilities of illness (or at any rate believe they have different probabilities) then those with low probabilities (or low perceived ones) may choose not to buy insurance because the premium has been set with high risk users in mind, while those with high probabilities (or perceptions) may eagerly seize their opportunity. If this happens, and insurers cannot identify those likely to demand more or less, insurers end up with clients who are likely to prove to be much costlier than expected; premiums will have to rise. High-risk high-cost individuals tend to drive out low-risk low-cost individuals. At the extreme, a 'death spiral' may result in which an insurance pool is completely emptied through rising premiums and consequential exit by the healthiest remaining individuals in the pool.

One solution to this problem is to require insurers to use community rating rather than risk-discriminate when setting their premiums, to cap the rates and subsidise the insurers. Another is to divorce the contribution and the benefit sides altogether by using the tax system to collect the revenue required and

either commission private providers of care or locate the provider side within the public sector. To the extent that the tax structure is proportional (ie, the proportion of tax paid is constant as the tax base – such as income – rises) or progressive (ie, tax liability as a proportion rises as one’s taxable income or wealth rises) the unfortunate implications of the gradient are reduced.

Underlying each of these four issues in insurance is a set of social value questions – who ought to determine the benefits and their terms of access, who ought to provide the insurance function, and what regulations and tax subsidy structure would best deliver the main policy objectives set for the health and social care system?

5 Equity versus equality

Equity is a common objective of the health and social care system (Le Grand 1990). It is not necessarily the same as equality or egalitarianism but it certainly relates in general to ethical judgements about the fairness of income and wealth distributions, distributions of costs and benefits, distributions of health, terms of access to health services, exposure to health-threatening hazards in workplaces, and so on. Although not the same as equality, equity frequently involves the equality of something (such as opportunity, health, access). Horizontal equity refers to the fairness (or equality) in the treatment of apparent equals (such as people with the same income). Vertical equity refers to fairness in the treatment of apparent unequals (such as people with different incomes or needs) and concerns fair inequalities. A distribution of something (such as health, income or health insurance costs) is said to be horizontally equitable when people are treated the same in some relevant respect. Thus, if the relevant respect (a social value judgement) is need, then a geographically equitable distribution of resources is one that treats people in localities with the same need in the same way. A distribution is vertically equitable when people who are different in some relevant way are treated appropriately differently. Thus, if the relevant respect is again need, an equitable geographical distribution of resources will accord more to those in greater need – how much more will probably entail further social value judgements, for example, relating to the impact of increasing resources on reducing need in that locality.

At the risk of some over-simplification, in health and social care the distribution of health itself is usually regarded as a matter of horizontal equity (ie, avoidable inequalities are inequitable). The distribution of transfer payments and subsidies, and out-of-pocket payments by people, tend to be matters of vertical equity (for example, personal subsidies might be equitably inversely related to income, benefits may be means tested). Inequalities in health care take-up are equitable or inequitable accordingly as they support or detract from greater equality in health, with the general (horizontal) presumption that equal health requires equal and cheap access possibilities. Cheapness of access matters especially at the primary care level as it is at this stage that needs are assessed. Without that assessment, needs cannot be properly identified and met and both the efficiency and the equity of the distribution of health and social care are prejudiced.

The principal social values involved here relate to the things whose distribution one is concerned about: burden of costs, receipt of benefits, types of cost or benefit, and whether or not the issue is one of horizontal or vertical equity. An important trap to avoid is to suppose that all inequality is inequitable. The essence of vertical equity is that to be equitable some distributions must be unequal. Another trap to avoid is to suppose that equality of access is of prime importance for equity in health. It is *cheapness* of access that matters. Equal terms of access that are prohibitive for large sections of the community may be equal but they will almost certainly be very inequitable on anyone's definition. Yet another trap is to suppose that all needs ought to be met. That is rarely possible. Instead equity requires needs to be met in a proportionate way to avoid some needs being met at the expense of the even greater needs of others (Culyer 2012c).

These concerns all vanish, needless to say, if equity in health, and equity in health and social care are not operational social values.

6 Inequalities of health versus inequalities of health care

Building on the foregoing discussion, it will usually be important to distinguish between the distribution of health and the distribution of health and social care. For example, if the social value judgement is to reduce avoidable inequalities of health, then it does not follow that a more equal distribution of health and social care is what is required. What is required will depend on the impact that different distributions of resources (eg, across social classes or geographical areas) have on reducing health inequalities. That will often depend on the underlying population health and demographic characteristics and the effectiveness of resources in preventing and tackling ill-health of the locally prevailing kind.

Whereas the work of NICE and the research community that supports it has done much to enhance our understanding of the effectiveness of health care interventions, much less is currently understood about the impact of social care, and relatively little is understood regarding the impact of interventions, new or old, on the distribution of health in the community. This must be one of the more urgent items on the research agenda of those giving a high priority to equity and distributive fairness in the NHS in England. Even something as simple in concept as identifying a baseline distribution of population health, applying a health and social care intervention, measuring the post-intervention distribution of health, and attributing the change to the intervention, is something not yet possible in practice (Asaria *et al* 2014).

A notable difference between the current arrangements for health care on the one hand and social care on the other is that the former is for the most part free at the point of use whereas many social care benefits are means tested. This asymmetry does not seem to follow from any principled social value judgement and it is hard to see how it can be maintained without perpetuating a profound ethical inconsistency.

7 Equity versus efficiency

Equity, both in the sense of the fairness of access to health and social care and the sense of removing avoidable inequalities of health, is often juxtaposed against efficiency in the sense of health maximisation subject to the given health and social care budgets. To see how this conflict appears to arise, suppose that we have an acceptable measure of health called them quality-adjusted life years (QALYs). It is fairly obvious that the value attached to maximising population QALYs implicitly assumes that one does not care to whom each QALY belongs. So, if the most cost-effective way of maximising QALYs required most of the health gain generated in the health and social care system to go to those with acute rather than chronic conditions because services for the chronically ill actually did little to prevent ill-health or to create better health, then one might well say that the approach lacked equity. The trouble here arises not because maximizing health is a bad value but because we have built into it a value assumption that a QALY=QALY=QALY, regardless of the identity of the person in whom the QALYs are embodied (Culyer 2006). The solution is – in principle – straightforward. We need to identify those cases we regard as warranting special consideration (chronic cases in the example), specifically according them a higher weight than the assumed unity attached to everyone under the QALY=QALY=QALY assumption. What that weight should be is, of course, a question of social value. A choice about weighting might be based on a survey of public opinion, or on the views of an accountable public officer (like a health minister), or according to the judgement of a panel like a citizens' council. Plainly value issues are involved in the selection of the methods used to reveal these value weights as well as in the choice of the weights themselves. They need not be quantitative but could be elicited according to some set of pre-established principles during a decision-making process. They ought probably not to be determined by vested interests or special patient advocacy groups, no matter how appealing their advocacy. Commonly asserted special cases demanding more generous weights include: those near death, those for whom a cost-ineffective intervention is the 'last chance', children, and people with rare diseases. Cancer is also a disease that attracts strong advocacy for its victims, especially when the treatment involves highly expensive drugs and the prospects of significant gains in either life or its quality are poor. Many of these treatments are not very cost-effective and it is not clear that the reason for their inclusion is based on equity. They do, of course, have substantial opportunity costs in the form of health forgone elsewhere in the system. If you balk at the thought of making such social value judgements, remember that the need to make them cannot be escaped by the QALY=QALY=QALY route. To assume unitary weights is no less a social value judgement than to assume non-unitary ones.

8 Needs versus wants

'Need' is arguably the most used and the least properly comprehended word in discussions of health and social care. It is evidently thoroughly impregnated with values. The meanings that attach to it are legion. Its persuasive power probably derives from a combination of two factors: one, the embodied implication that the entity asserted to be needed is actually necessary; the other, that this needed entity ought to be provided/received. To elucidate what any particular writer may be getting at, it is often helpful to ask what the thing said to be needed is needed for, and what the interests are of whoever is specifying that it is needed (given the ever present fact that whenever a professional is deciding what someone needs they are nearly always identifying a source of income for themselves). From this one might enquire as to whether there are other means than the one asserted to be needed – especially ones that may be more effective, or more cost-effective, and whether the person specifying the need is appropriately qualified (eg, by training, accountability or responsibility). One may also enquire as to the social value, moral worth etc, of the outcome for which the thing said to be needed is necessary (if it is necessary). In this way, some analytical content might be injected into what otherwise is in danger of being mere sloganising (Culyer 2012d).

It is invariably a good practice to distinguish between a need for health and a need for health and social care.

Important and difficult issues remain concerning, for example, whether any particular need ought to be met and how much of it ought to be met. In prioritising needs, one can reach for the tools of cost-effectiveness analysis, which can indeed be helpful, not least in exposing the necessity for making social value judgements and interpersonal comparisons of health and illness.

The most frequently met practical measures of need at the community level are morbidity and mortality data. They plainly imply a need for health though not necessarily a need for health or social care (which may not be effective in altering either for the better and, even if they are, may not be the most cost-effective general instruments available). Other concepts include capacity to benefit from care (which is an outcome measure if the underlying thing needed is health or social care) and the resources that are necessary to reduce capacity to benefit to zero (ie, to the point at which the marginal benefit of care of any kind falls to zero). There are manifest and formidable problems of measurement with both of these.

Need is often used as a criterion for adjusting the geographical distribution of resources in the interests of fairness or equity. One may want to think about this in terms of the resources that are most cost effective in improving the health of the population and, especially, the health of those who have the poorest health, thereby not only helping to ensure that health and social care resources go where they generate most benefit but also that they go disproportionately to communities that have both the capacity to benefit and a low initial health base. It is also worth bearing in mind again that achieving a more equal distribution of health may involve significantly unequal allocations of health and social care resources.

9 Prices versus rationing

A general definition of rationing is 'allocating resources according to a rule or administrative arrangement'. One rule might, for example, be 'resources shall go to whoever is willing to pay the highest price'. Such a rule does not much commend itself in health care however, since those most in need of health care are, thanks to the gradient, usually those least able to pay for it. The most common general usage of rationing is in connection with (usually wartime) arrangements under which, in exchange for a voucher or ration coupon, individuals (or families) are entitled to buy fixed quotas of goods at administered prices. A lot of tendentious hot air is generated in public debates about whether health care in any jurisdiction is or ought to be 'rationed'. Those with political responsibility are understandably unwilling to concede that health care is rationed in either of the two ways just described but they are often less understandably willing to concede that some form of rationing mechanism does indeed have to be used; resources do not exist that are sufficient to meet every demand or even need for health and social care, so the critical question relates not to 'whether' but to 'which' method should be used to determine who gets what. There is also debate about the desirability of being explicit about the criteria to be used in determining which method to use.

It may be useful to think about rationing at various levels of decision-making. What criteria are appropriate at each level? How, for example, ought resources to be rationed between health and social care on the one hand or education on the other – the level of broad public sector budget setting – or, only a little lower, between health care and social care? Another level is the NICE level at which decisions are made about which procedures and interventions are to be available, to be used at the professional discretion and judgement of individual professionals in the light of individual patient circumstances. Another level might be the allocation of commissioning budgets to providers for populations in a specific locality. Yet another is the individual, face-to-face level of patient and professional, where the professional will have to think about how best to deploy the resources at their disposal.

10 Financial protection versus quality of life

The initial reasons for founding the NHS probably lay in the removal of the adverse financial consequences of needing health and social care, either because the cost denied people access altogether or because the cost actually incurred was catastrophic. Mere insurance is not a sufficient escape from these bad consequences because, as shown earlier, the poorest, thanks to the gradient, are likely to face the highest premiums. Social insurance and, in particular, the use of the general tax mechanism to fund health and social care provision did, however, effectively break that link. What remained only came into focus somewhat after the Second World War, as concerns were raised about the mounting share of national income occupied by health and social care. That concern eventually transformed itself into a concern for value for money (a social value) and the search for means of identifying the contributions that health and social care services can make to better health and quality of life and their more equal distribution (all empirical questions).

The search for humane and effective methods for determining the optimal spend on health and social care continues. Its current banners are 'evidence-based decision-making' and 'cost-effective provision'. The object under the former banner is to seek evidence for claims about the value of services. Not to do this can lead to disastrous consequences as we saw earlier in connection with technologies as different as drugs and settling babies in their cots.

Evidence-based medicine (EBM) is the practice of medicine informed by the best available evidence of effectiveness and other empirically amenable aspects of the clinical management of a patient (Guyatt 1991). There is a lot of argument as to what constitutes evidence and the weight to put upon different kinds (for example, evidence from randomised controlled trials or from observational studies or from 'professional experience'). There is remarkably little evidence that EBM leads to better health outcomes for patients, though it must be said that this is absence of (good) evidence rather than (good) evidence of absence of effect. Many people prefer the term 'evidence-informed' on the entirely reasonable grounds that there is more to decision-making than mere evidence.

Cost-effectiveness analysis is a method of comparing the opportunity costs of alternative health and social care interventions which have a common benefit or outcome (Drummond et al 2005). It is used when outcomes are difficult to value monetarily, when those that are measurable are not commensurable, or when the objectives are set in terms of health itself. Cost-effectiveness analysis (or health technology assessment) is the preferred method of NICE. The idea of opportunity cost is critical. Since the budgets for health and social care are set by Parliament, more spending on one technology or patient group or geographical area inevitably means less spending on others. This 'other' spending may be presumed to have yielded health benefits so the object in cost-effectiveness analysis is to minimise the loss of such benefits. The idea may be approximated by saying that cost-effectiveness analysis is a means of helping decision-makers to maximise the net impact of NHS and social care resources on health: for NICE, that is the difference between the gains expected from using a technology in specified ways and the health that would have been gained by distributing the same resources in monetary terms in some other way within the system. NICE uses a generic measure

of health, quality adjusted life years (QALYs), that enables comparisons of cost-effectiveness to be made across many different technologies and patient groups. Some gurus advocate the use of the term cost-utility analysis, which is in all essentials the same approach. The term health technology assessment is similarly used, referring to the combination of epidemiological, economic and biostatistical methods in assessing the potential contribution of health and social care to health and welfare.

Some ethicists object to the use of any health measure that involves length of life on the grounds that it leads to discrimination against those with short expectations of life, arguing instead that 'a life is a life' and that all lifesaving resources should be equitably allocated randomly (Harris 2005). Others argue that long extensions to life are generally to be preferred to shorter ones, so such discrimination is not in fact objectionable. Of course, it may be that people with short expectations of life are deserving of special treatment, like others who command one's sympathies, in which case their potential health gains may be weighted more heavily, although how much more heavily is a deeply value-laden judgement.

Those who attempt conscientiously to use evidence in their decision-making commonly need to confront the following issues: the absence of scientific research (clinical, economic, social) on an important aspect of the matter to hand; a too narrow interpretation of 'scientific' (eg, to exclude economic and social evidence of a statistical kind); the irrelevance in part or whole of such research as may exist; the need for interpretational skills that they do not have (especially with multidisciplinary material or evidence from disciplines not represented within the decision-making group); research of poor quality; research that is dated; research (even high-quality research) whose outcomes are ambiguous and conditional on unknown factors; research that is controversial and contested by expert researchers in the field; research of high quality when judged by a criterion such as internal validity (the results have had as much bias as possible removed through the design of the study) but poor when judged by another such as external validity (the results apply even when the intervention is used in other settings); research that is of one level in respect of its clinical or epidemiological quality or completeness but of another in respect of its economic or social character; the need to supplement research evidence by the practical experience of clinicians and other professionals either to 'fill gaps' in knowledge or to form judgements about the quality and relevance of such research as exists; non-technical issues as to whether a technology is *sufficiently* effective to warrant recommendation/use; non-technical issues as to whether a technology's probable benefits justify the costs that can be attributed to its introduction and use and the associated risks attached to its use; how much uncertainty to accept and how best to hedge against risks; how best to explain to stakeholders how all such factors have been balanced.

Many of the issues that arise in cost-effectiveness analyses are deeply imbued with social value judgements. For example, they:

- tend to assume that the main objective is to maximise population health as well as reducing avoidable health inequalities
- tend to focus on cost and benefit consequences for patients and only sometimes on their immediate families, let alone consequences for remoter people

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- tend to take a particular view of what health is: usually described in terms of physical and cognitive functioning (the QALY is one example)
 - base the adding up of scores for the elements of the QALY measure on surveys of public opinion.

While none of these is patently unreasonable, each can be challenged and there is always more than one way in which the challenges to which these are the current solutions could have been faced. Above all, it is apparent that a high social value is likely to be placed upon transparency and accountability and there are many stages at which it may be desirable to encourage public participation in decision-making, a topic returned to later.

11 Public versus private

The terms public and private are the sources of endless value-laden confusion in health and social care discussion. It is worth separating out several critical aspects:

- the ownership of insurance-providing or care-providing agencies may be public or private
- privately owned agencies may be for-profit or non-profit (such as charities and churches) or ambiguous (such as not-only-for-profit partnerships)
- private insurance may support care in public care agencies and *vice versa*
- public insurance may support care by for-profit agencies
- owners such as shareholders or partners in a partnership may or may not be profit-seekers
- all agencies have to ensure that they deliver services as required by their controlling authority, whether it be public or private.

These points contain intriguing combinations of means and ends. Is one to regard the form of ownership as an end and as having important social values inherent within it, or are the types of ownership merely alternative means to other ends, like fair pay and efficient and kindly care? Is a hard-to-manage publicly owned system better or worse than a well-managed private system (or *vice versa*)? What weight ought one to attach to the work ethics and social values that service providers claim to possess? Are they ends or means? Are they anyway to be believed? What sort of evidence might one seek to settle the matter?

One important issue confronting policy-makers in the UK is whether it is easier to get service providers to deliver services to the desired standard and at the desired cost by using external contracts (as when a public commissioner commissions from private for-profit or non-profit providers) or by using 'internal' contracts when there is a direct managerial line of accountability from the Department of Health (or NHS England) to the provider or from central government via local authorities to the provider. The question of whether it is 'easier' is not itself one of social values, but one of effective delivery of policies that embody social values. Of course, one may attach *intrinsic* value to public (or private) provision, and many do, but a question worth trying to answer is whether the more fundamental issue of value does not actually relate to the manageability of policy implementation; thus whether it is better done by private or public, or for-profit or non-profit agencies is really an empirical question, to which there is still no clear answer and which may in any case vary according to the kind and complexity of the service in question, how much it has to be integrated with other services, and what local traditions and cultures prevail among providers and clients.

I know of no ultimate empirical solution, so the matter remains one of judgement and, often, ideology – a *practical judgement* about what is most likely to be the case and a *social value judgement* about the sorts of outcomes we are seeking.

Economists have a special definition of public as in 'public good' that does not depend directly on an ownership question. A public good in this sense is a good or service from which it is not possible to exclude people once it is produced. Clean air and street lighting are classic examples. Public goods are non-rival in the sense that providing more for one person does not entail another having any less. Most public goods are not wholly public in this sense and whether health care itself has significant public good characteristics is a point of debate. Some programmes (especially those called public health) have considerable public good characteristics and even the care consumed by an individual may have a public aspect by virtue of any caring externality that others may feel. While public goods in this specialised sense can be produced in the private sector, the general presumption is that they will be under-produced so some form of subsidy is required for increased output. Public ownership is another possibility but by no means the only way of obtaining appropriate rates of production of public goods. What is effective is more a question of 'what works' than of social values – unless, of course, social value attaches inherently to public (or private) ownership, that is, the various forms of ownership are treated as ends rather than merely a means to other ends.

12 Agents versus principals

The private/public issue is related to the notion of principal–agent relationships. The principal is the person on whose behalf the service is being provided, the agent provides the service or advises the principal concerning it. Principal–agent relationships are characteristic of personal services whose nature is technical and even scientific but whose effects are personal. For many people, their relationship with their garage mechanic is of this kind – they are the principals, the garage employees are the agents. One trusts the mechanic to know both what the car needs and to provide it. One may immediately see that the distinction between demand and supply becomes blurred – the agent (often the supplier) tells the principal what needs to be done to the car and effectively becomes not only the supplier of the service but also its demander. Trust is therefore at the core of the agency relationship since fraud and deception are real possibilities.

More generally, the agent is anyone acting on behalf of a principal, usually because of asymmetry of information. The agent knows more about the technical characteristics of the service while the principal knows more about the values, needs, circumstances, and fears of the client. In health and social care, the role of a physician or other professional lies in determining the client's best interest and acting in a fashion consistent with it. The client is the principal and the professional is the agent. In health and social care, other examples include service managers acting as agents for their principals such as owners of firms or ministers, regulators as agents for politically accountable ministers, ministers as agents for the electorate. Thus many people find themselves being both agents and principals.

In health care, the situation can become even more complicated by virtue of the fact that doctors are expected to act not only for the patient but also for society in the form, say, of other patients or of an organisation with wider societal responsibilities (like a care commissioner), or taxpayers, or all potential patients. The agency relationship can also give rise to the problem of supplier-induced demand. This is care provided at the expense of the client or a third-party payer like an insurer, but which is not really of benefit to the patient/client or not of a benefit that is commensurate with its cost of provision. Systems in which the agent's financial rewards are linked directly to service provision have this inherent bias, as when doctors not only prescribe but also dispense drugs, or when GPs are paid on a fee-for-service basis. If hospitals are compensated by an average daily rate per occupied bed, they have an incentive to increase length of stay since the later days in hospital are characteristically the lower cost days; this is a form of supplier-induced demand.

The critical social value question here lies perhaps in creating a trusting relationship throughout the chain of principals/agents in which the principal's interests are always to the fore and the agent's reward is either linked to the satisfactory meeting of the principal's needs (payment for results) or separated entirely from it with reliance being placed on the dutiful observance of professional codes of practice, clinical guidelines, the Quality and Outcomes Framework, pride in practice, and associated monitoring and enforcement, by professional associations, royal colleges, statutory regulators and the like. As with the public/private issues, I know of no ultimate empirical solution, so the matter remains one of judgement and, often, ideology.

13 Universality versus selectivity

Universality is a commonly desired characteristic of a health care system, sometimes required by statute. It refers to the extent of coverage of people with entitlement to use the service or a package of insured services when in need of them without user charge, or with only nominal charges. 'Universal' customarily implies 'everyone', though whether this means all citizens, all residents, all resident citizens or some other broad, but not necessarily all-encompassing, definition is not always clear. Selectivity tends to be exclusive, ie, those with the means to pay either for insurance cover or out-of-pocket for services when received are excluded from the subsidised provision, or may access it at some additional charge to the nominal charges paid by those entitled under universal coverage.

The ethical tension between the two arises principally from the fact that the public expenditure implications of universal coverage are higher than they are under selective systems, so it appears not to be a cost-effective way of subsidising health care, while social cohesion or solidarity are better served by universality than selectivity. This is a direct clash of values: cost-effective support for the needy on the one hand (with the associated 'spare' resources that would be available for other social purposes) versus the sense of 'we're all in it together' and this sense being embodied in well-loved institutional forms (like the NHS).

Selective systems also imply that there would be a greater role for private insurance cover and private provision of care for those excluded from, or opting out of, the universal system. This can be expected to lead to claims of 'double payment' and political pressure in a tax-financed system for a favourable adjustment for those not entitled to care under universal cover.

14 **Comprehensiveness versus limited benefit bundles**

Comprehensiveness as a characteristic of a health care system relates to the range of services that are or ought to be provided, typically including all those deemed medically necessary (which is not equivalent to cost-effective, nor an unambiguous idea). It usually covers inpatient and outpatient care, and community based services including pharmacy, dentistry and ophthalmology services. In general, the more comprehensive the coverage, the greater the cost to the insured person (if entitlement is through payment of premiums), or to the third party insurer (the insurance company or the state).

The main issues of social value arise in defining what is in and what is not in the 'insured bundle' of services. Ineffective services and procedures may be an easy class about which to decide. Services about which there is controversy and inconclusive evidence as to effectiveness, for example, so-called 'fringe medicine', may be candidates for exclusion. Services about which there is little evidence but a reasonable expectation that they may be effective might be eligible for inclusion on the basis that they are provided only in conjunction with research designed to test their (cost) effectiveness. Services and interventions for which there is good evidence and which fall below the upper limit of the marginal willingness to pay (the so-called NICE threshold – currently roughly £20,000 per QALY), or which offered advantages in reducing avoidable health inequalities, might have a strong case for inclusion.

15 Centralisation versus decentralisation

A value attaches to keeping decisions in the NHS and social services close to patients and clients. One reason for this is doubtless a belief that social values are not homogeneous and vary according to locality, local history and traditions, local health and epidemiological characteristics, local environmental conditions, local socio-economic characteristics such as ethnicity and language, local income and wealth, and local knowledge and understandings of these attributes. Against these reasons for decentralising are the need for national standards, the need for scarce technical skills (for example, in commissioning or delivering specialist care) which may not be replicable at the appropriate standards in all local communities, and the general desirability of having simple organisational structures that are responsive, transparent, accountable and that do not cost the earth. Our knowledge about 'what works' in this territory of design and decision-making is woefully inadequate!

16 Competition versus collaboration

Most of the concerns that are likely to be raised under this heading are likely to relate to such things as protection of quality, avoidance of conspiracy and collusion, optimal sizes of provider agencies, workplace flexibility and fairness, and the links these have to ultimate NHS values. However, there may be intrinsic social values that incline one's judgement one way or another, and it may be that there are special reasons why what is acceptable in other spheres of productive activity are not acceptable in the NHS. These are most likely to relate to notions of 'solidarity', 'public service' and other such terms. The trick is to tease out the substance from the self-serving rhetoric. It is probably a mistake to attribute base motives to those preferring one over the other, or to those preferring to work in one rather than the other environment. The better approach would be to seek the analytical reasons why one might be preferable to the other, and the circumstances under which this might or might not be the case.

17 Experts versus citizens

When social values are involved in decisions, as they nearly always are, it becomes important to figure out ways of introducing them into decision-making processes. This will often involve the creation of bodies – boards, advisory councils and the like – on which laypeople are represented. It is an important value (I contend) that the social value judgements of scientists, clinicians, social workers and ‘experts’ in general, are no more worthy of special weight than those of ordinary citizens. At the same time, these ‘expert’ groups rarely admit to a due humility when it comes to expressing social value judgements! It should not be forgotten that, as far as medicine and social care are concerned, rocket scientists, famous painters, headteachers and archaeologists are all lay people. However, expertise in something else that is non-medical is not required before one can articulate a social value judgement. Just ‘being’ is enough. It is probably worth ensuring that people with potentially conflicting interests ought to be excluded from some levels of community participation. It is also worth remembering that other personal characteristics can usually be identified as suitable criteria for selection; criteria such as ability to express an opinion in a semi-public situation, not having a domineering personality, ability to listen in a focused way to arguments and evidence for reasonable periods of time (Culyer 2012a).

18 Mixing values and other things

Decisions about the financing of health care, the benefits available, the terms of their access, and who they are available to, are always decisions that values alone cannot resolve. Nor can medical science alone resolve them. They can be resolved only by combining principles that embody social values with evidence about the impact that procedures, broadly conceived, have on health and well-being and their distribution across the population. This is true of decisions about who has entitlement, the size of one's financial contribution, the use or not of co-payments, their size if used, the set of technologies available, the circumstances under which alternative procedures are best employed, the use of professional and clinical guidelines, the location of facilities, the concentration of health and social care expertise, the decentralisation of decision-making, the ways in which health and social care professionals are paid, the extent to which providers are involved in the commissioning of local services (the so-called purchaser-provider split)... In all these cases, and in many more, one needs also to understand the causal chains involved in clinical judgements, the adequacy of the science underlying modern medicine and social care technologies, the behavioural features that matter in each case, the short- and long-term impacts and the management challenges to the system. In all cases, evidence is rarely perfect and judgement – not only *social value* judgement – is needed: judgement about what evidence is good enough to use, judgement about timing so that highly uncertain impacts can be piloted and rolled out as better evidence is obtained, judgement about what the public finds acceptable, judgement about the political acceptability of some judgements (including those that go against common but mistaken popular beliefs). But *social value* judgement is also nearly always needed too!

19 Key messages

The key messages are all questions that ask 'what is the social value content?' and 'what implications does it have for the design and running of the NHS and social services?' Other, unquestionably related, questions, for example about what clinical, managerial and governance arrangements work, or work best, are set aside here but will always lurk alongside the moral questions. The key messages that follow are divided into those that arise in the context of the broad character of the NHS and social care and those that arise once some of the broad issues have been settled.

Social value questions regarding the general design and structure of the NHS and social care

- What, if anything, makes health and social care significantly different in ethical terms from other goods and services consumed in the UK?
- Are the big questions of social value regarding the NHS and social care to do with their objectives, their processes, or both?
 - If objectives, is it possible to articulate what the social values involved are?
 - If processes, is it possible to articulate which processes most need attention?
- Is a 'fair distribution of health' a suitable objective? What kind of equalities and inequalities might achieving such a fair distribution entail?
- Whose social value judgements should NHS and social care procedures embody: those of politicians? patients? potential patients? informal carers? taxpayers? professionals (which ones)? other 'experts'? citizens? residents?
- Ought the NHS and social care to be seen as a response to a general feeling of sympathy and caring that most people have for the welfare of fellow humans, or simply as an efficient and fair system of insurance for essentially selfish people?
 - If the former, what implications are there for the design of the services?
 - If the latter, what implications are there for the design of the services?
- What issues of social value arise in deciding the best balance to strike between reliance on private and public insurance (assume that both public and private health and social care providers are available whichever type of insurance is chosen)?
- What issues of social value arise in deciding the best balance between private non-profit, private for-profit and public health and social care providers?
- What issues of social value arise in deciding the share for each of health and social care in their overall budgetary envelope?
- Is the integration of health and social care valued for its own sake or because it can lead to better and more fairly distributed set of outcomes?

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- If for its own sake, what is the ethical reasoning here?
 - If for its consequences for health, what other questions of social value arise?
 - If for both, does this raise ethical conflicts that need resolving?
 - What issues of social value arise in choosing between publicly owned service providers and ones managed through contracts with independent care providers?
 - What issues of social value arise in deciding the size of financial contributions to come from individuals and families?
 - Should the principles determining client payments for service (or exemptions) be the same in health and social care?
 - What issues of social value arise in deciding the best balance to strike between reliance on public and private providers of health and social care (assume that both public and private insurance will give access to the care needed)?
 - What issues of social value arise in considering the decisions that ought to be delegated to local bodies and those that should be retained at the centre?
 - What issues of social value arise in deciding who may participate in public decision-making in health and social care service provision and planning, the mode of that participation and the level of decision-making?
 - What issues of social value arise in allocating resources to commissioners and providers of health and social care in the regions of the country?
 - What issues of social value arise in choosing between competition and collaboration between providers?

Social value questions of a more specific nature

- What issues of social value arise in deciding which health and social care procedures and interventions should be available?
- Should the NHS and social services ever provide cost-ineffective care?
- If the opportunity cost of providing more care of one kind is the outcome lost through providing less of another kind, how does one compare and evaluate the outcome gain and the outcome loss?
- What issues of social value arise in deciding the balance to strike between services provided without user payments and those with, or groups who would not pay and other groups who would?
- Do people who have multiple disadvantages deserve especially favourable treatment in terms of health and social care even though their capacity to benefit may be small?
- What issues of social value arise in selecting ways of rationing health and social care when demand outstrips supply?
- What issues of social value arise in deciding whether long waits for treatment are better or worse than long waiting lists (few people waiting ages vs many people waiting little)?

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- What issues of social value arise in choosing measures such as changes in mortality, morbidity or QALYs as outcome indicators?
 - What issues of value arise in translating needs for health and independent living into needs for health and social care?
 - What issues of social value arise in selecting alternative methods of pay for health and social care professionals: fee-for-service, rewards for meeting targets, salaries?

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About the author

Tony Culyer currently holds the Ontario Chair in Health Policy in Toronto, Canada, and is Professor of Economics at the University of York, where for many years he was Head of the Department of Economics and Deputy Vice-Chancellor. He was Chief Scientist at the Institute for Work and Health in Toronto, Canada. He chairs the Advisory Committee of NICE International and is Editor-in-Chief of the online Encyclopaedia of Health Economics. He was Vice Chair of NICE from its foundation until 2003. He was founding editor of *Journal of Health Economics* and was on the boards of *BMJ* and *Journal of Medical Ethics*. He was the first organiser of the Health Economists' Study Group, is a Founding Fellow of the Academy of Medical Sciences, an honorary fellow of the Royal College of Physicians, a CBE and has an honorary doctorate from the Stockholm School of Economics. His most recent book is *The humble economist*, an edited collection of his less technical papers.