PAPER

The NHS and market forces in healthcare: the need for organisational ethics

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ABSTRACT

The NHS in England is an organisation undergoing substantial change. The passage of the Health and Social Care Act 2012, consolidates and builds on previous health policies and introduces further 'market-style' reforms of the NHS. One of the main aspects of these reforms is to encourage private and third sector providers to deliver NHS services. The rationale for this is to foster a more competitive market in healthcare to encourage greater efficiency and innovation. This changing healthcare environment in the English NHS sharpens the need for attention to be paid to the ethical operation of healthcare organisations. All healthcare organisations need to consider the ethical aspects of their operation, whether state or privately run. However, the changes in the type of organisations used to provide healthcare (such as commercial companies) can create new relationships and ethical tensions. This paper will chart the development of organisational ethics as a concern in applied ethics and how it arose in the USA largely owing to changes in the organisation of healthcare financing and provision. It will be argued that an analogous transition is happening in the NHS in England. The paper will conclude with suggestions for the development of organisational ethics programmes to address some of the possible ethical issues raised by this new healthcare environment that incorporates both private and public sector providers.

INTRODUCTION

The NHS in England is an organisation undergoing substantial change. The passage of the bill which became the Health and Social Care Act 2012, consolidates previous health polices and introduces further 'market-style' reforms of the NHS: encouraging private and third sector providers to foster a more competitive commercial market in healthcare. Such a changing environment sharpens the need for attention to be paid to the ethical operation of healthcare organisations. This paper will chart the development of organisational ethics as a concern in applied ethics and how it arose in the USA largely owing to changes in the organisation of healthcare financing and provision. It will be argued that an analogous transition is happening in the NHS in England and the possible ethical implications of this will be discussed. The paper will conclude with suggestions for the development of organisational ethics programmes in the UK to address some of the possible ethical issues raised by this changing healthcare environment.

THE GROWTH OF ORGANISATIONAL ETHICS

A growing body of work in the area of 'organisational ethics' seeks to direct attention to the ethical attributes and functions of organisations rather than focusing, as much of healthcare ethics has done, on individual relationships.[1–4] Organisational ethics is the examination of 'the ethical implications of organisational decisions and practice on patients, staff and the community'.[3] This is claimed to be a natural progression for bioethics, a turn towards an ecological version of bioethics that considers 'the moral sociology of organisations'.[5] and the broader context of individuals as biosocial organisms. Important questions for study from an organisational ethics perspective are: What are the organisation's alleged aims and values (sometimes contained in a mission statement)? How does the organisation behave ethically in its financial and business arrangements? What are the organisation's work practices, policies, promotion criteria, organisational structures? How does the organisation manage conflicts of interest? What are an organisation's duties to its stakeholders? How do the organisation's activities affect the wider community?

Organisational ethics is another variant of applied ethics such as professional, clinical and business ethics. Areas of applied ethics have traditionally been differentiated by their area of focus, so clinical ethics has considered the issues raised by clinical practice and global ethics issues arising from global interactions and relationships. They all seek to bring ethical analysis to bear on practical problems and have often prioritised different theoretical tools to deal with their area of interest. Whether these different types of applied ethics can be seen as clearly differentiated categories is contestable and hence whether organisational ethics is a distinctive sub-area debatable—all areas of applied ethics share overlapping concerns and theoretical similarities. However, by having the organisation as the focus (rather than the doctor–patient interaction, for example) new questions and areas are opened up for consideration. The approach of Spencer *et al*[1] to organisational ethics will be taken in this paper. They argue that organisational ethics can best be seen as, 'a process or strategy for adjudicating different stakeholder... views in an organisation', rather than a commitment to a particular set of normative theories.

Organisational ethics in healthcare has applied theories generally used in business ethics to healthcare. Spencer *et al*[1] make a case for integrating stakeholder theory with perspectives from clinical, healthcare and professional ethics to produce a

comprehensive organisational perspective. Stakeholder theory is: 'An approach to business ethics that takes into account the rights and interests of the broad range of individuals and organizations who interact with and are affected by business decision-making'.[4] A number of authors have developed this approach to theorise the complexity of organisational ethical obligations and attributes.[1 2 4]

Stakeholder theory get its normative force from the conceptualisation of the relationships between stakeholders, each stakeholder's interests are of intrinsic value—that is, 'stakeholder relationships are normative reciprocal relationships for which each party is accountable'.[4] This theory is useful for thinking through: the obligations (and limits of these) of an organisation; who counts as a stakeholder; the parameters of these obligations (both internal and external to an organisation); and the relationships between stakeholders (the organisation and its patients, its staff and staff and patients). As Werhane sums up, 'Stakeholder theory provides a moral framework for evaluating not only stakeholder relationships but also evaluating organizations, their missions, and their value-creating activities. Thus stakeholder theory initiates thinking about *organization* ethics for healthcare, while including the stakeholder dimensions of professional, clinical, and managerial ethics'.[4]

All organisations have to think about how they function ethically. Commercial organizations are required to operate in accordance with the legal structures governing employee welfare and the safety of their products, for example, and some go beyond this with a commitment to fostering social goods (eg, Marks & Spencer's 'There is no plan B' environmental commitments). However, it has been argued that healthcare organisations have ethical obligations in addition to those usually required and these distinguish them from other kinds of organisation. Many authors have used a variety of arguments to demonstrate that healthcare is not analogous to other market-exchange commodities: the vulnerability of most healthcare patients; the necessity for professional excellence; asymmetries of information and conceptualisations of healthcare as a social good from which flows concerns over equity of access and justice for example.[5] These features of healthcare mean that organisational ethics for healthcare organisations will have distinctive concerns and theories must be tailored or adapted to adequately address them. Spencer *et al*[1] consequently argue that stakeholder theory needs to be reworked to ensure that fostering patient and population health should be given priority when making decisions.

The growth in interest in organisational ethics can be seen to have philosophical roots,[1 6] but this interest was also stimulated by the social and political context of healthcare provision in the USA in the late 1980s and early 1990s. The development of managed care and the dual responsibilities of healthcare organisations to run as businesses produced fears that healthcare was becoming increasingly commercialised with detrimental effects on patient care.[7] Medicine has always involved money changing hands from the earliest ancient Greek physicians. However, there was a perception that money was becoming the dominant focus and traditional moral motives and professionalism were under threat. Various special editions of bioethics journals were published on the ethical implications of these developments such as the *Cambridge Quarterly of Healthcare Ethics* in 2007 and the *Journal of Medicine and Philosophy* in 1999 and Relman, a former editor of the *New England Journal of Medicine*, wrote extensively on the dangers of these trends in healthcare provision. 'The continued privatisation of healthcare and the continued prevalence and intrusion of market forces in the practice of medicine will not only bankrupt the healthcare system, but also will inevitably undermine the ethical foundations of medical practice and dissolve the moral precepts that have historically defined the medical profession'.[8]

Such concerns over the ethical operation of healthcare organisations were exemplified by the development in 1995 of standards by the Joint Commission on Accreditation of Healthcare Organisations (JCAHO)[9] to ensure that hospitals' business practices were conducted ethically. This was a recognition that the boundary between clinical ethics and business ethics can break down in healthcare and business practices need to be subjected to ethical scrutiny in the same way as the doctor–patient relationship in clinical ethics.[9] Organisational ethics developed out of a period of transition in the organisation of healthcare in the USA. It will be argued that the organisation of the NHS is undergoing a similar wholesale change, with an increasing focus on market mechanisms to provide healthcare.

HEALTHCARE POLICY IN ENGLAND

The NHS has changed considerably in the past 30 years. From a near state monopoly of healthcare provision we now have a health service characterised by a wider diversity of providers. There are, currently, almost 2500 independent hospitals and clinics offering a wide variety of services.[10] Many diverse policy and social trends have led to these reforms[11]: the development of an internal market within the NHS by successive conservative governments since 1979; an increase in managerialism in the NHS and public services more generally in the form of new public management; and a gradual cross-party acceptance that market mechanisms are an appropriate and efficient way of delivering healthcare. The justifications for this creation of a market in healthcare have been set out in policy documents spanning 30 years and can be summarised as[11 12]: a belief that the private sector is better managed; that market forces will encourage leaner more efficient service provision and help contain costs; that competition and patient choice will drive quality and innovation; and that a decentralised health service will be more responsive to local needs and encourage citizen participation.

The culmination of these policies was the passage of the Health and Social Care Act in 2012, the central aim of which is to create a more competitive market in healthcare. There are two ways such a market could be created: by payment and/or provider reform. The way healthcare is paid for in the UK is through taxation and it is free at the point of delivery (although there are subsidised prescription charges). The 2012 Act does not propose to change this fundamental aspect of the NHS, but does propose changes to the way in which healthcare is commissioned (bought) by creating a national NHS commissioning board. This will oversee clinical commissioning groups that will have responsibility for commissioning services for their local populations replacing primary care trusts and strategic health authorities. The aim of these consortiums is to give more local control and be more sensitive to market mechanisms. The Act will extend the role of the regulatory body Monitor, to oversee this 'market' and ensure that this competitive environment is functioning properly.

The Act will accelerate moves to encourage other organisations outside the NHS (eg, private and third sector providers) to bid for services previously offered by the NHS. The 'any qualified provider' initiative'[13] will enable patients to choose from a range of providers from different sectors: commercial, third sector and the NHS. The central aim of this diversification of providers is to increase patient choice and stimulate

competition between these different providers. 'By 2013 providers from the independent sector will play a bigger part in delivering services to NHS patients'.[14]

The healthcare system in England is in a similar state of change and transition as the American system in the early 1990s with new types of healthcare organisations coming in to provide care and new financial relationships being created. Any form of healthcare organisation needs to consider the way it operates ethically, whether state or privately run, but the change in structure and type of healthcare providers sharpens the need for this kind of consideration. There are particular ethical tensions created by opening up the NHS to commercial providers and creating a system with a diversity of different types of providers (public, private and third sector).

ETHICAL ASPECTS OF THIS NEW ENVIRONMENT

The purpose of this paper is not to debate whether these moves to a more market-orientated healthcare system are, in themselves, a positive or negative development,[15] but to focus on what kind of ethical issues might arise in this new healthcare environment and how these might be managed. The term commercialisation and 'market' in healthcare are notoriously difficult to define and are often used in multiple ways. Callahan and Wasunna[16] make a distinction between two levels of market intervention: first, those that aim for fundamental change, that include privatisation of parts of the system, moving them out of government hands; and, second, those that aim for market mechanisms to improve efficiency without changing the underlying system. The healthcare reforms in the 2012 Act aim to bring about the first conception of a market in healthcare,[15] and build on the previous health reforms that achieved the latter. Many authors have pointed out that these healthcare reforms will lead to the expansion of use of commercial providers.[12 16 17] The increasing commercialisation and corporatisation of healthcare is something that has been debated in other disciplines, but relatively little attention has been paid to the ethical aspects of this topic in the UK.[18]

A number of possible ethical concerns may arise as a result of the increasing use of providers outside the NHS. With the increase in private providers conflicts of interest might be created—such as a conflict between patient welfare and the profit-making aims of an organisation. There is much more evidence for the possible problems that might arise in the US context owing to their established market in healthcare.[2 7] Perry and Stone[19] give a good overview of some of the problems such conflicts create: overtreatment of patients (for instance, for-profit facilities giving drugs in excess of clinical guidelines); referral on the grounds of business interest not patient welfare; lowering staff ratios; and in their own area of hospice care, the rise of for-profit hospices has resulted in 'selective recruitment of a longer-term, increasingly non-cancerous, population of Medicare patients and the payment of lower salaries and benefits to less-skilled staff'.[19] McCloskey *et al*[20] in a study of the effects of organisational and financial changes brought about by managed care in the USA in midwifery, argued that provision of care to vulnerable women and those at social risk decreased with these new financial arrangements.

It is difficult to infer whether problems faced by the US system would arise in the UK with its very different culture and organisational structure of health provision. There is some evidence from the UK to suggest that the more commercialised environment is already influencing healthcare delivery. A recent study on the views of nursing staff who had relocated to independent sector treatment centres (ISTCs) (which are private providers of routine and low-risk care) from the NHS found that, 'clinicians described new ways of working as extending managerial or corporate control over clinical practice … the apparent construction of professionalism within ISTCs related less to professional knowledge, skills and competence and more to meeting stipulated guidelines or performance indicators. As such clinicians revealed a new idea of professionalism within the independent sector'.[21] One nurse in their study said: 'We're not a supermarket, so don't try and turn us into (supermarket name). They might be really efficient and make lots of money but they are doing something different'.[21] How much the ethical obligations of professionals are altered or compromised in a commercial environment is a subject for further study. However, concepts of professionalism that operate within these private providers are changing: with efficiency and performance indicators taking centre stage.

In November 2011 Hinchingbrooke was the first NHS hospital to be taken over by a private company, Circle Health. In the share prospectus the company issued when it was floated on the stock exchange in 2011, it explicitly recognises that its business interests may, 'affect its ability to provide a consistent level of service to its patients'.[22] Although this is a statement of risk that any company must provide on floatation, and is a worst case scenario, it demonstrates that private companies such as Circle Health operate as businesses and therefore this might comprise their ability to provide an acceptable level of consistent care. Recent reports suggest that Circle is facing financial problems and has not been able to make the cost savings expected at Hinchingbrooke.[23] Such companies have obligations to their shareholders to ensure that their services are translated into profits and dividends which, arguably, can create a conflict of interest that could threaten patient care.

The system that is evolving will still maintain a large amount of provision by NHS organisations with independent providers bidding for particular services, sometimes in conjunction with NHS organisations. Monitor, the body set up to oversee this new market in healthcare, will have three functions: to oversee competition; regulate prices and ensure continuity of care. The ethical problems raised by this type of system, owing to its novelty, are as yet unknown. One possible concern might be the problem of market failure. It has been argued that the new system, in order to stimulate competition, will allow more market failure than there has been in the past. Although, Monitor has additional powers to regulate specific services if they are failing, this aspect of competition needs to be balanced against protecting patients.[24] With the dual system of provision, how the burden of market failure will effect NHS organisations is a complex problem. A further possible concern is ensuring equity of healthcare provision. The 2012 Act has set up health and wellbeing boards to oversee healthcare at a population level and deal with health inequalities. How these boards will operate and if they will be able to reduce inequalities remains to be seen.[25]

How this developing market in healthcare will function in England and what the increasing diversity of sectors involved will mean in practice is uncertain. Healthcare is a vastly complex business: how to measure the effects of market operations, what would count as evidence in this area and how to determine exactly which policies cause which effects are difficult and contested issues.[16] However, there is a need for all NHS organisations to consider how they operate ethically and new types of provider entering the market place must also deal with the ethical aspects of their practice.

ORGANISATIONAL ETHICS IN PRACTICE

Given the changing face of healthcare provision in England, with moves towards a diversity of providers from different sectors and the potential for new types of ethical issues being raised, a closer attention to ethical aspects of organisational functioning is timely. As stated above, a reworked form of stakeholder theory has been advanced as a useful way of conceptualising the relationships, duties and obligations between the different stakeholders and the central importance of patient and population welfare in these deliberations. This theoretical framing can point to ways that these complex relationships and interactions can be examined and how such relationships can be ethically conducted.[1] In this section ways that this might be approached in the English context will be considered.

Examining the expressed goals of healthcare providers[2] and how these set out the parameters for the relationships between the different stakeholders is often a starting point for organisational ethics programmes. In recent years the NHS has developed a form of mission statement. Lord Darzi's review of the NHS in 2008 recommended that the NHS should have a constitution and the first one was published in 2009: 'establish(ing) the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively'.[26] The context for this is summarised by this statement from the NHS Institute for Innovation and Improvement: 'As our healthcare system becomes increasingly devolved, autonomous and entrepreneurial, there is a need for system-wide values, which reaffirm the social purpose of the NHS, to staff, patients and the public and inspire behaviours that put the needs of patients, staff and the public foremost in people's minds.[27] The Health Act 2009 stipulated that all bodies providing NHS services (NHS, private and third sector providers) must 'have regard' to the Constitution in all their actions and decisions. Therefore, ensuring that constitutional values are upheld could be a useful way of ensuring general values and ethical standards are shared between different healthcare providers. Although useful in principle, using the Constitution in this way raises a number of issues.

First, the NHS Constitution is a document designed primarily for NHS organisations and this raises the question of how applicable it is to non-NHS healthcare organisations? The central tenet of the Constitution is the right to access NHS services free of charge (for the patient). This does not speak to independent provision, as owing to the payment model, such organisations are funded by the NHS budget to provide care. The NHS Constitution does not put into place any new legally binding requirements on organisations, but brings together elements such as employment law, health acts, negligence and common law provision.[28] Therefore, independent organisations are already subject to many of the provisions laid out in the Constitution. A key difference is the section on rights for staff where it gives specific provision for staff of NHS organisations (ie, the right to employment protection). But it also includes pledges (non-legally binding 'goals') that independent organisations should have regard to—for example, that all employees should have rewarding jobs. As a document attempting to set out the 'ethos' that should underpin healthcare provision it could be argued that it applies to all healthcare organisations. How particular values are enacted in practice is a matter for all forms of healthcare organisation (both public and private) and there is a drive to make organisations and patients more aware of the Constitution to increase its influence on practice.[29] Second, there is the question of how compliance with the Constitutions' pledges is policed? Who ensures that the increasingly diverse range of healthcare providers will adhere to these values? And, in practice what does 'have regard' to the Constitution actually mean? The 2012 Health Act includes a provision that clinical commissioning groups must promote the Constitution and they will be held to account by the NHS commissioning board.[29]

The issue of ensuring compliance with any organisational ethics initiative is important. Hospital accreditation bodies in the USA and Canada have incorporated organisational ethics compliance into their accreditation standards.[3] The JCAHO standards have been in operation since 1995 and while conclusive evidence that they have improved health provision is elusive, the Veterans Health Administration (the largest provider of integrated healthcare in the USA) sees these standards as beneficial.[30] They state that the processes that this accreditation requires to be put in place (eg, monitoring codes of ethical behaviour) ensure that these issues are addressed in the organisation. Further, the inspection process includes ad hoc ethics discussions with practitioners, that might consider (among other things) if they are aware of the ethical policies in their area. The process of gaining accreditation, therefore, provides a focus for the organisation's consideration of the ethical aspects of its practice and external monitoring means that it takes place.

This form of accreditation could be a model for England. All providers have to be registered with the Care Quality Commission (CQC) and they are inspected at regular intervals to ensure they are providing care of a suitable standard. These existing quality monitoring processes could be extended to set out the standards for organisational ethics. As part of their submission to the CQC, providers could be formally required to address the ethical aspects of their operation by demonstrating awareness of such and measures they have taken to deal with the overall ethical quality of their organisation.

The link between the ethical aspects of care and quality of health is becoming increasingly recognised.[31 32] As Nelson *et al*[32] point out when there are ethical failures the quality of care is diminished and when quality is compromised that also presents an ethical problem. They argue there is 'potential to address ethical issues using well-established quality improvement approaches'.[32] Thus, an organisational ethics programme could be integrated into the existing quality improvement mechanisms of healthcare organisations and monitored through the CQC. There are possible limitations to such an approach: quality governance programmes have been argued to be largely exercises in setting up procedural requirements that have little impact on quality. This is reflected in recent moves towards measuring outcomes for patients and not just focusing on monitoring processes.[33] In the area of organisational ethics, such outcomes may be hard to specify.

One way to put an organisational ethics programmes into action in England is to build on the existing clinical ethics committees (CECs). McClimans *et al*[31] have argued that CECs can play a role in meeting CQC's existing standards and this could be further extended to coordinating the organisational ethics aspects of a provider's submissions to the CQC as suggested above. They suggest that CECs could revise their terms of reference to take on a more integrated role in their Trust and could benefit from taking on members of the administration who

have expertise in healthcare business, so that this dimension can be included. They also see a preventative role for CECs in auditing cases that they receive to see if there are any recurrent themes and evidence of system failures that produce ethical problems. This highlights the changing role of ethics programmes in institutions and the move from a reactive service to a more preventative organisational approach.[32] There could be practical difficulties to expanding the role of CECs that would need to be solved—for instance, the lack of expert staff, particularly those trained specifically in ethics and organisational time and commitment.

An example of an initiative that attempts to incorporate all these elements into an organisational ethics programme is the IntegratedEthics programme instituted at the Veterans Health Administration in the USA.[34] This programme considers three levels of ethics: decisions and actions; systems and processes; environment and culture. The first level is broadly clinical ethics as usually conceived, such as ethics consultation. The second level is a consideration of the systems and processes that 'create' ethical issues—systemic ethical issues—and seeks to prevent such issues arising. Their approach addresses these in two ways: general maintenance activities and quality improvement cycles. Maintenance activities might be updating ethical policies; providing ethics education for staff and conducting ethical surveys to determine where there are possible problems. The quality improvement cycles are specific interventions to address a particular ethics quality gap—for instance, ensuring all patients have a next of kin documented. The third level is dealing with the organisational culture of the organisation by considering how leadership of an organisation can promote an ethically aware organisation. For instance, performance targets could include ethical dimensions and a culture fostered that promotes and values ethical behaviour and prioritises it as much as organisational efficiency.

CONCLUSIONS

How programmes of organisational ethics might work in the new healthcare environment in England and be integrated into existing quality monitoring is something that needs to be explored by further research. Despite some of the difficulties mentioned with the practical implementation of organisational ethics programmes, they fulfil an important need in this new healthcare environment. Such programmes alone cannot ensure ethical practice, but they can begin to highlight the importance of the ethical aspects of an organisation's operation. The ethical dimensions of these new organisational forms, new provider relationships and a health sector that combines public and private provision should not be ignored.

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