Do you think the NHS can cut costs while improving care?
Send us your views and suggestions (through our rapid responses on bmj.com) for treatments that could be stopped in your area of practice

Trade-offs are unavoidable

The recent financial crisis and subsequent economic recession have placed healthcare systems in most parts of the world under extreme pressure. Expensive technological developments, the substantial cost of highly trained labour, and increasing longevity make health care a highly demanding and costly industry. And even before the recession, rising healthcare expenditure was a preoccupation for many governments. Politicians, their constituents, and the entire health industry now face an enormous challenge to find new directions in policy.

Beyond the cultural, political, and ideological arguments that have been extensively discussed,[1] there are three critical broad objectives with inherent policy trade-offs that must be considered in any debate on healthcare policy: high quality, disciplined funding, and maximum coverage. Coverage generally refers to the percentage of a country's population eligible for state healthcare services and the comprehensiveness of these services.[2] Quality refers to the efficiency and effectiveness of the healthcare services provided,[3] and funding refers to the public expenditures for health care incurred by taxpayers.[4]

The problem is that these three objectives cannot all be achieved concurrently.[5] Structurally intrinsic trade-offs mean that, at most, only two of the three objectives can be satisfied simultaneously—and satisfying any two will always come at the expense of the third. Government efforts to improve health care in the UK provide many examples to choose from.

Would you like to minimise funding while maintaining or even enhancing quality? Promising to do just this for dentistry, the government introduced a new NHS dental contract in April 2006 that actually harmed coverage: 300 000 people lost their NHS dentist in a single month and 900 000 fewer patients saw an NHS dentist in 2008.[6-8]

Would you prefer to minimise funding without compromising coverage? This will come at the expense of quality. Under the Conservative government from 1979 to 1997, the healthcare budget remained stable despite rising drug costs, an ageing population, and mounting costs for advanced technology. The result: long queues for hospital admissions, insufficient availability of modern diagnostic technologies, rationing of some high technology medical services, and a failure to upgrade or replace outdated hospital and health centre facilities.[9]

Do you wish to pursue both high quality and greater coverage? If so, forget about tight fiscal constraints. Prime Minister Blair's policy of increasing healthcare spending to meet average European Union standards almost doubled the budget of the NHS.[10] The new resources brought enormous change, both in the quality of health care and access to services. From 1999 to 2009 the NHS saw an increase in the number of doctors, greater funding for services, and massive drops in waiting times for inpatient and outpatient treatment.[11]

Patently, a government resolved to implement major budget cuts must accept reduced standards for the other two objectives. Public officials are naturally loath to discuss reductions in either eligibility for services (that is, coverage) or quality. Yet something will be compromised—quality, coverage, or, most likely, both. Funding cuts implemented through reductions in staffing will reduce the efficiency and effectiveness of the services—that is, reduce quality. At the same time, the fact that patients may no longer be able to see the specialist they wish to consult erodes the formal volume of coverage. Some patients will accept the reduced choice; others will pay to access the services they desire.

Such trade-offs between three desirable objectives have been called trilemmas.[12] Unfortunately, policy literature has shown that instead of seeking a "least bad balance" between funding, coverage, and quality, politicians faced with a trilemma tend to resort to simplistic promises[13] such as "health budgets will be immune," "improvements can be achieved at lower costs," or "health services can both be better and cost less." Alternatively, they maintain that efficiency can be best achieved by promoting competition and encouraging the private sector. Yet it is the public that both funds these policies and feels the effect of any policy changes, and blinding the public with simplicities is neither fair nor wise.

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The public deserves to understand the complexity of any change to healthcare policy. Only through knowledge and understanding can people enter into a dialogue whereby policy options can be discussed and agreed.

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See EDITORIAL, p 605, FEATURE, p 622, PERSONAL VIEW, p 657

BMJ/King's Fund Debate

On 27 April the *BMJ* and King's Fund are holding a debate on the motion, "This House believes that the NHS will not be able to cut costs without substantially damaging the quality of care" (www.kingsfund.org.uk/learn/conferences_and_seminars/improving_services.html)

FROM BMJ.COM

Banned words, and other blogs

Julian Sheather rants about banned words
I know not whether to laugh or cry. Into my inbox popped an index prohibitorum drawn up by the Local Government Association: a list of words that must not be used when providing information to the public. As a word haunted liberal I am immediately—and quite properly for a liberal—in several minds. I don't like censorship, but will I really miss the phrase "meaningful reusable interactivity"? Unlikely. "Externalities"? Never. But my joy at the flushing out of so much linguistic slurry—no more "brain dumps" or "thought showers," no more "trialogues" or "webinars"—is edged with sadness at the reminder this list brings of the verbal sludge still flowing.

Tony Waterston updates us on climate change and maternal and child health
Connecting four countries by video on a Friday afternoon could be an exercise in technological disaster. But with obstetricians, midwives, and paediatricians present at the delivery, a safe and healthy passage was guaranteed, and indeed all went smoothly at the first global conference on climate change and maternal and child health held at the Royal College of Obstetricians and Gynaecologists in London. The data and ideas presented were of huge value and illustrated the need for an urgent and collaborative approach to tackle climate change now.

Becky Freeman asks: "Is an iPhone good for your health?" Health and lifestyle apps are among the most popular to both purchase and download for free. Having trouble sleeping? There's an app for that. How about an app that tracks your diet and calories consumed? Check. New Year's resolution to quit smoking? There are more than fifty apps to help you break the habit. This may all sound rather innocuous, but digging a bit deeper reveals a distinct lack of evidence supporting the mythical claims of some of these apps.

bmj blogs Read these and other *BMJ* blogs at http://blogs.bmj.com/bmj

Doctors on doc2doc are asking what's in a name

Calling doctors "surgeons" and "physicians" Is it just semantics that stops a nurse practitioner calling himself or herself "doctor"? After all, they see patients in clinics and prescribe treatments. And why shouldn't a care assistant who washes and feeds a patient, and holds his or her hand when they are frightened, be called a nurse? Is the UK's hospital hierarchy, with many nurses educated to PhD level, confused? Would confusion be eliminated if doctors without doctorate degrees referred to themselves by the titles they have earned (for example, "physician" or "surgeon")?

rmtracey: "The term doctor has, for many years, carried a certain connotation. It means a legally qualified medical practitioner. But now with vets, surgeons, dentists, chiropractors, and everyone else calling themselves doctor, the term is rapidly losing its original meaning. In the end, who cares? You know who and what you are and what your worth is. If others want to gain some kudos from sitting on your coat tails so be it."

AndyK: "It's interesting that nurse, paramedic, physiotherapist, and so on are all protected titles, but there is nothing to stop people calling themselves doctor (look at Gillian McKeith)."

Yasao: "In Arabic we have two different words: 'tabeeb,' which means a medical doctor, and 'doctor,' which can simply refer to anyone who has graduated with a PhD . . . problem solved."

Reay: "How sad . . . it's all about status and envy."

Odysesseus: "In my part of the Greater Antipodes, everyone is called doctor. For example, we have saw doctors who sharpen saws, and my dentist is now doctor along with the chiropractor, iridologist, homeopath, osteopath, psychopath, and so on. Add to this the fact that to get a job here you need to have a PhD, and Bob's your uncle. Indeed, I recently saw a patient doing a PhD in Education on long division!"

What should different healthcare professionals call themselves? Have your say at http://tr.im/RWYq