Summary

In recent decades, there has rightly been considerable emphasis on the rights of patients. By contrast, very little attention has been given to the responsibilities and obligations that patients have. The times are changing, however. The shared financial burden of providing health care is soaring. As a result, people reasonably expect their fellow citizens to make prudent and efficient use of the health care system. Furthermore, developments in the way care is provided demand more active input from patients. Changes to the care system also imply a greater acceptance of responsibility by the patient.

Against this background, there is a need for 'good patientship'. But what does being a good patient involve, and how should good patientship be realized? And, in particular: what can a patient reasonably be held responsible for, and how can patients be held to account while protecting the vulnerable and preserving the accessibility of care? The Council believes that it is time such issues were debated, and hopes to set such a debate in motion with this report.

In the Council's view, good patientship implies the acceptance of responsibility under three headings:
- Adherence to generally accepted standards of interpersonal behaviour: patients should show care practitioners respect; this means that they should not be aggressive, should not make unreasonable demands and should keep their appointments.
- Fulfilment of commercial obligations: patients should take out appropriate medical insurance and should pay the associated premiums and personal contributions on time.
- Cooperation with treatment: patients should keep their care practitioners properly informed, talk issues over with them and participate in the formulation of treatment decisions; patients should also follow the instructions, advice and lifestyle guidance they are given.

At present, patients do not always live up to these responsibilities. It is therefore pertinent to ask whether policies should be introduced, with a view to encouraging good patientship. There are various widely accepted ways in which fulfilment of responsibilities of the first two kinds already can be – and is – encouraged. For example, many care establishments have football-style systems of yellow and red cards, which are used to keep aggressive or over-assertive patients in line. The principle of no-show charges for patients who fail to keep appointments without a valid reason is also well established, and people who fail to take out insurance or pay their premiums are liable to face financial penalties. Enforcing acceptance of the patient's responsibilities under the third heading is another matter. Little scope exists for making people cooperate with treatment, even though such cooperation has the potential to yield greater public health and efficiency benefits than fulfilment of the other responsibilities described above.

The Council has assessed a number of (possible) ways of promoting good patientship, by application of the following questions:
- Would the measure in question be effective: is it likely to elicit the behavioural change that is sought?
- Is the measure justified: would it have any significant adverse effects, such as undermining patient-carer relations, infringing the patient's right to self-determination, restricting access to care or undermining communal solidarity?

The measures selected for assessment are examples of a much greater range of possible measures, which involve everything from encouragement to enforcement. At one end of the spectrum, the Council looked at ways of rewarding good behaviour and, at the other, of imposing financial penalties on people who do not fulfil their responsibilities.

On the basis of its assessment, the Council gives the following guidance:

Good patientship can be encouraged by promoting (cost-) awareness among the general public (the patient population) and by providing incentives for healthy lifestyle decisions. Care practitioners should do more to call patients to account for irresponsible behaviour and should define boundaries where necessary. They should make greater use of existing options, such as downgrading treatment goals in cases where patients habitually fail to cooperate. If they are to pursue such policies, care practitioners need to believe that they have support. To this end, the development of noncompliance protocols can be advantageous.

The imposition of financial sanctions through the health insurance system is inadvisable. Although such measures might ease the pressure on solidarity (by showing people that their fellow citizens pay for the problems they cause),

they are unlikely to bring about the desired behavioural changes. If the government were to impose such measures, serious opposition could be expected, not only from patients, but also from care practitioners and insurers. Behaviour is more likely to be influenced by financial disincentives to the purchase of 'unhealthy' products, such as higher taxes on alcohol, cigarettes and fast food.

The Council would like to see more public debate about personal responsibility in relation to health. It is envisaged that such debate would help to make patients (more) aware of their responsibilities and to motivate care practitioners to improve their services, client-focus and skills. However, its chief benefit would be a clearer definition of (the enforceability of) patients' personal responsibilities, and of the boundaries of the services that care practitioners may be expected to provide.

To promote such debate, the Council is to follow up this study with a round of conferences involving patients, care practitioners and other stakeholders, starting in February 2008. The conclusions of these conferences will be published in due course.