JournalScan

The problem with rational approaches to reforming the NHS

Compiled by Tom Smith

Several papers with a common theme published between May and August 2002 are drawn together to present a research-informed critique of economic logic present within recent NHS reform. They attempt to persuade the reader that excessive faith in predictive systems of thought that are underpinned by theories of rational behaviour is misplaced within the NHS. They suggest rational economic theory makes some problematic assumptions about human and individual behaviour. The problem is that there are many modes of thought at work within the NHS, and not all of these cogs are turned by economic rationality.

Increasingly, over the last 10 years or so, economic concepts have become more and more prominent in the NHS. Their influence has gone beyond finance becoming a dominant issue. In addition to budgets, contracts and cost itemisation, theoretical relationships of supply and demand are now called upon to change professional behaviour. A new framework for the NHS has been built which is developing market forces. The papers provide some insight into whether the systems set in place to produce a patient-centred service do so in a meaningful way.

The first paper examines an emerging primary care group (PCG). Now part of primary care trusts, PCGs were a lynchpin of new economic relationships in the new NHS. Community based, in theory PCGs take decisions made about healthcare resources closer to the patient for whom they are a proxy demander and shaper of services. To what extent do PCGs fulfil this role? The first paper is based on data collected during an in-depth 2 year observation study to test the applicability of health economics to healthcare organisations. It examines the early experience of commissioning services for coronary heart disease (CHD).

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Can health care be planned rationally?

Economic ways of thinking as well as a new vocabulary have spread rapidly in the NHS over the past 25 years. The researcher was interested in the extent to which the input of health economics was influential in the decision making framework of NHS organisations. Her involvement began in 1997 and lasted until 1999. Setting guidelines for the prescription of statins was the first difficult decision the research observed. At the beginning, "within the health authority (HA), the unofficial view was that the drugs should be rationed, with younger patients receiving priority. An economic analysis by the HA medical director had been ignored since it demonstrated that the cost effectiveness of these drugs increases with age. The HA dilemma was that, since no additional resources were available and options for disinvestment were extremely limited, any guideline that promoted increased expenditure could not be approved." Their decision making was constrained by the need to follow a rational economic model of planning.

But this economic perspective is not in tune with many in the NHS. The PCG ignored the HA advice. There was no compulsion to follow it. There is no new money to invest and guidance "is to help doctors to set priorities for treatment with statins", but "is not intended to replace or override clinical judgement in individual cases", leaving judgement entirely at the whim of local decision makers.

The problem for economic assumptions in reform is that the research found the PCG's decision making process was "markedly at odds with the 'rational' health economic approach". As an example, a decision to fund a clinic is described. The CHD group decided to fund a hospital clinic for chest pain at the request of the hospital consultant on the committee despite the absence of option appraisal, strategic analysis or a cost benefit analysis. "Although the consultant cardiologist was asked by the author to provide information on the service currently purchased by a neighbouring HA, he steadfastly refused, arguing that, once funded, this service could be monitored on an ongoing basis".

So which patients would be treated, how would they be selected, and their care managed? There was little consideration

of these issues. Because it was not clear how much money was available, it was agreed another meeting would discuss "which groups should be targeted first, how often the clinic should be run and the costs". "In other words", says the author, "having agreed to fund a development, the PCG would buy whatever could be afforded when it learned how much it could afford".

As the author notes, a key limitation to adopting an economically rational view is that "in contrast to 'rational' health economic approaches", decisions made in the NHS are not necessarily predicated "on the prior identification of objectives". Situations are dealt with as they are found. Interestingly, the author suggests that this may produce a more effective outcome than rational planning. Attempts by the HA to follow a rational approach reduced it to "a state of paralysis". The author says it was precisely the "lack of consideration of issues such as overall service objectives and resource availability" that enabled the PCG to make decisions.

Given the tension between a lack of resources and the need to develop services, informal decisions are more functional. But what does this mean for access, for equity, for health population planning, and other non-economic aims of the NHS? It is likely that PCTs will respond to immediate priorities and political pressures. It means any attempt to restrict "the power of individual GPs to allocate resources according to their own discretion risks undermining the ability of the system to cope with the gap between supply and demand".

The system cannot assume the existence of local economic rationality in decision making. Although "part of the ostensible rationale for devolving decision making to PCGs is that this brings the process closer to the patient, in practice", says the author, "this brings decision making closer to local practitioners who appear to focus on those aspects of care that are relevant to their own immediate environment". They are not necessarily equipped to think economically.

The researcher judged the priorities of decision makers to be actions that "would alleviate pressures on their own workload". This value overlays any system incentive and corrupts any "rational" option appraisal system. The inferred aims of decisions were to follow a "more is better" philosophy as long as GPs were not required to take on additional workloads.

The decision making process was reactive, in stark contrast to the "theoretical ideal, synonymous with the rational health economics approach". Causal behaviours were not considered. "In reality, aspects of CHD services were taken in manageable chunks with no consideration of the linkages between these elements".

Assumptions about the capacity of the PCG to achieve the greatest good for the greatest number might be informed by the finding that "the discourse of commissioning at PCG meetings was characterised by reference to case vignettes and the GP role in responding to individuals as opposed to population health planning".

Perhaps the paper unkindly judges clinicians' priorities in making decisions, even though it raises some vital questions about the relationship between person and role in economic theory. It may be that rational systems of thought inevitably label any dissent as "irrational", defined in the dictionary as *unreasonable*. It may be more true to say that many clinicians do not share an economic mode of rationality. As the author says, "judgements as to what represents rational policy making change according to who is making the judgement".

▲ **McDonald R.** Street-level bureaucrats: heart disease, health economics and policy in a primary care group. *Health and Social Care in the Community* 2002;10:129–35

Are patients rational consumers of health care?

A paper from the *British Journal of Management* examines public and professional views of consumerism in the Scottish NHS. One of the mantras of management at the moment is the reorientation of care around the needs of the patient. A paper from a marketing perspective "critically examines the reaction of both patients and professionals to politically driven initiatives to re-orientate the delivery of health care services" to a more consumerist model.

The paper argues that the Government has introduced notions of consumerism, in part, as a behavioural symbol for professionals to change their identity in relation to patients. "The application of commercially derived marketing concepts has been central to the reorientation of public sector service provision. Central to breaking this producer dominance has been the idea that service users should be viewed as consumers whose demands will shape change more effectively than the Government acting as a proxy consumer."

The paper is interested in what it sees as an implied change in relationship as a result of "consumerisation". "From being a relationship couched in terms of citizenship with myriad mutual commitments and obligations on the part of the citizen, it is increasingly expressed in consumerist terms, with emphasis placed on the primacy of the rights of service users, both individually and collectively".

The authors are sympathetic to the thinking of the NHS, however. In trying to make health care transparent to the consumer, NHS policy places "emphasis on the processual or experiential aspects of healthcare service delivery" to focus organisational attention on quality. The problem is that this logic depends on consumers behaving as "rational, sovereign and seeking to maximize the benefits of personal acts of choice"—the "implication being that consumers use the same criteria to choose a doctor as they would any other product". The authors surveyed 2000 Scottish patients to explore the extent to which individual relationships to the health service could be compared with more established consumer relationships in different sectors.

The authors argue that models founded on economic rationality models are not easily applied to the NHS. "The reason rational assumptions of consumer behaviour do not hold in health care", say the authors, "is the problematic relationship between the consumer and the professionals". Instead of believing some products are inferior to others, "the patient has a considerable investment in believing in the ability of the doctor and the superiority of professional knowledge". The consumerist approach cannot accommodate "this power relationship" that "implies that patients have the knowledge and understanding to influence professional judgement".

It might be argued, what is it that is so special about health care? There are other professions exploiting inequality of power too, which still profit from a "consumer relationship"—for example, financial services and law. True, but the problem, say the authors, is that, more than in any other professional-consumer relationship, there is an unrivalled "emotional investment" on the part of the consumer who is also more focused on the outcome than the process.

Although in other industries where it is difficult for the consumer to judge the outcome the process provides a proxy measure, "the data suggest this is not the case in health care". The data collected show that "the outcome dimension in health care is overwhelmingly important". "What makes the difference", say the authors, "is an 'emotional investment' on the part of the consumer, requiring a relationship based trust that mitigates against conventional consumerist patterns of behaviour". Another important factor militating against rational consumer behaviour is that 2000 Scottish people think "funded health services constitute public rather than private goods".

"This is not to suggest that service users are necessarily satisfied with the overall nature and dynamics of the healthcare service encounter, as ongoing concerns about poor communication highlight, but rather that the majority of service users seek change within the existing format of the service encounter, as opposed to any radical reconfiguration of the service encounter".

▲ **Laing A.** Hogg G. Political exhortation, patient expectation and professional execution: perspectives on the consumerisation of health care. *Br J Management* 2002;13:173–89

▼ An anti-market perspective does not necessarily motivate the critique against the application of economic theory to health services. It should be emphasised it is the assumptions of rationality that are difficult to apply. These difficulties do not only relate to economic theory. They also relate to our expectations of how ill people make choices about their health. As the following paper shows, these are not rationally motivated.

Do elderly patients plan rationally for serious ill health?

A paper in the *BMJ* examined the extent to which "elderly patients think about and approach future illness". In-depth 2 hour interviews were held with 20 chronically ill housebound patients aged 75 and over based in a working class community within east Baltimore by researchers from John Hopkins University.

"Planning in advance is widely encouraged as a way to improve quality of care at the end of life." But "the willingness to consider future illness ... is not universal". Many of those interviewed (men, women, black, white) were reluctant to think about the future per se, not just their future health. "For many patients these were lifelong views; others had adopted these attitudes as they became elderly and infirm. This was an unexpected finding on a topic about which we had not specifically asked." A few talked about the immediate future in terms of wanting their health to improve or their living arrangements, but "these remarks show a limited view of the future".

Nineteen of the 20 "were particularly reluctant to think about, discuss, or plan for serious future illness". Why are people resistant to talking about the future? One person said, "I don't want to face it yet"; another said "if you dwell on it then you have a problem ... you can make yourself miserable". Not everyone is a planner. Instead, people talked about taking things "one day at a time", preferring "to cross that bridge" when they come to it. Many of the group believed their future to be "God's domain". "I think the Lord is just gonna take me some night in my sleep". "What will be will be".

The interviewers tried to explain to the group "the rationale for advance planning and urged them to consider the predicament of doctors trying to make decisions about treatment in the absence of information about patient preferences. While most did not alter their views, after repeated questioning a subgroup [of six] said they would be willing to listen and perhaps talk with doctors about these issues, although several were ambivalent."

"Curiously, despite most of these people not thinking about or planning for the future, many had made 'final arrangements' for their death." Thirteen had made a will and 19 had "funeral plans or cemetery plots". People prepare for death, but not for serious illness.

"Our participants seemed to divide the future into three distinct segments, which they approached differently: firstly, an uncertain contingent future that may be accompanied by chronic and

serious illness, which they are generally unwilling to plan for or even contemplate; secondly, a time when death is near and certain, which they are somewhat more likely to plan for and discuss; and thirdly, the event of death itself and what follows, for which they are likely to have made arrangements."

The findings highlight a central difficulty in planning for "end of life care". The time between their present state of health and their death is the "interval" in which "the most difficult decisions often arise: patients must choose between a burdensome treatment that offers the chance of longer life or a more palliative course that offers less suffering but at the cost of dying sooner". Patients plan for a certain future—for example, death—but not for what they regard as uncertain, chronic illness in later life.

The authors concluded that their findings "do not argue against advance planning; rather they identify additional limitations to the conventional model for making decisions about serious future illness".

▲ Carrese J, Mullaney J, Faden R, Finucane T. Planning for death but not serious future illness: qualitative study of housebound elderly patients. *BMJ* 2002;325:125

- ▼ Knowing that there are limits to rationality is not especially helpful. Doesn't this lead to gridlock? A paper from Sweden suggests that a better understanding of different perspectives and underlying motives might allow ways of incorporating negotiation of different rationale. It focuses on how different groups prioritise treatment.

Is it possible to make transparent rationing decisions?

With limits to healthcare resources, prioritising the access of certain patients becomes necessary. "Obviously, some kind of priority order within the public health care system has to be agreed on, but opinions differ greatly on the principles on which to base such order." Prioritising "is a matter of values and opinions" about appropriate criteria.

A study in *Qualitative Health Research* set out to examine the decision making process and overriding judgement criteria of clinicians, health service officials, and patients in the prioritisation of resources in Sweden. It explored different judgements on rationing through a survey of patients and by recording clinicians and health officials "thinking aloud" while making judgements on case vignettes and a qualitative analysis of the transcriptions. Each vignette was a one page summary of individual applications to receive publicly funded psychotherapy. There were some similarities between the healthcare officials and the laypersons who both tended to "focus on the urgency of the case from a social or humanitarian point of view", but the clinicians differed clearly from the other two groups. They "tried to balance such considerations against the apparent suitability of the case for psychotherapeutic treatment".

All three groups agreed on only four cases, two who should receive treatment and two who should not. The cases that were prioritised satisfied the healthcare officials and laypersons—a young woman removed from a violent family and brought up in foster care—the clinicians saw her previous positive results from the therapy. She was now applying for continued support. The cases all parties agreed to reject failed to satisfy either the "urgency" or "suitability" categories that healthcare officials/laypersons and clinicians, respectively, prioritised. For example, one case rejected was a 40 year old male journalist who had "recently realised that his relations to women were too distant" and that "he shunned closeness". Neither group thought this put him among the most deserving cases.

Clinicians and healthcare officials/laypersons disagreed in the majority of cases. Why is this? "With the larger group of patients between the two poles that united the judges, prioritisation appeared to be much more complicated and led to different decisions with different judges." One case provides an illustrative example. A 34 year old married woman with two small children came to Sweden as a 16 year old immigrant from eastern Europe. Shortly after the birth of her second child, both grandparents and her mother died. She experienced a "deep and long-lasting depression and was hospitalised for a year". One year of psychotherapy helped her get back to work as a television producer, and

she now sought subsidisation to continue psychotherapy. "Almost all clinicians were for prioritisation, whereas a large majority of healthcare officials were against it. The laypersons were evenly split. The clinicians took the positive psychotherapy experiences as an indication of her suitability for this kind of treatment, whereas the healthcare officials, viewing the matter from the point of view of just distribution of societal resources, believed that she had already had her share of free treatment."

In general, the healthcare officials and laypeople were concerned with what they judged to be urgency, and the clinicians were concerned with suitability for treatment. By implication, if society was interested in a form of prioritisation that satisfied each, both elements would have to be present in the criteria.

What makes a case urgent? A key question posed by the researchers is whether urgency relates only to those with a psychiatric diagnosis or whether it can be applied to people who are judged to require therapy to prevent a psychiatric diagnosis. "Does the responsibility of the health care system also include preventing ill health?" "It is interesting to note that many clinicians used a psychiatric diagnosis as a marker of urgency but not of suitability."

What makes someone suitable for treatment? "The most frequent arguments for a patient's suitability were that he or she had a previous profitable experience of psychotherapy; that some self-reflecting capacity was indicated; and that he or she seemed to be motivated to work with himself and appeared to be prepared to change." The authors find this interesting and counter "if the previous psychotherapy had been wholly satisfactory, the patients would be not coming back for more".

The researchers collected some data in Australia, the UK, and India and so claim some cross-cultural consistency. Prioritisation is inevitable. For it to be made explicit "one precondition exists: prioritising criteria must be accepted as fair and valid, not only by healthcare professionals and politicians but among all members of society".

▲ Fredelius G, Sandell R, Lindqvist C. Who should receive subsidized psychotherapy? Analysis of decision makers' think-aloud protocols. *Qual Health Res* 2002;12:640–54

- ▼ A key insight presented by the papers is that rational calculations often miss important variables from their equations: the existence of different professional and personal perspectives as well as power struggles between different decision making processes employed to distribute healthcare resources. Sometimes decisions taken to save money show far higher cultural costs than the guiding rationale accounts for. Mergers are a case in point.

Questioning the rationale behind mergers

It is not only in the clinical and social worlds that rationality must be questioned, but also in the managerial world. Not all decisions are wholly rational. A paper in the *BMJ* explored the process and impact of mergers between NHS trusts based on interviews with 96 board members, clinicians, service managers, and other health officers. They aimed to identify the "stated" and "unstated" (not publicly stated) objectives of each merger.

One aim of merger is to achieve economic gains by taking advantage of economies of scale and scope (especially with regard to management costs) and as a result of rationalising the provision of services. It is also argued that trusts "with a single focus can provide higher quality services". Other publicly stated reasons include: "invest savings into services for patients, safeguard specialist units, and ensuring that quality and amount of services provided were maintained". The unstated drivers were concerned with specific local issues. These included a need to impose new management regimes on trusts perceived by health authorities or regional office as "undermanaged" or "lacking control", and to negotiate reductions in accumulated deficits of one of the constituent trusts (which one trust could not bear alone).

All four cases of merger studied by the research team showed "that the mergers had a negative effect on the delivery and development of services". "Senior management had underestimated the timescale and effort involved in the mergers." There were some

positive effects on service development, for example, "that there would be more clinicians in small services to run them effectively". The creation of large trusts means that there is a larger pool of professional staff. But merger also means that "senior managers had become remote, and service managers felt cut off from the services they were managing". Management lost their focus on the service and people who had been used to relating directly to senior management "now had to deal mainly with middle management" which, some felt, "compromised strategic developments". Management structures after the merger "tended to consist predominantly of staff from one of the constituent trusts; this created the impression of a 'takeover' for many staff".

While there were savings in management costs, these were not to the degree anticipated. "The low savings in management costs achieved particularly in the first year after the merger suggests that the implementation of mergers needed more management support than had been anticipated. Merged organisations thus need to set realistic objectives in terms of savings in management costs by taking into account the amount of managerial input needed to implement the merger."

The paper concludes by saying that "important unintended consequences need to be accounted for when mergers are planned" and "other organisations undergoing restructuring . . . should take these findings into account".

▲ **Fulop N**, Protosaltis G, Hutchings A, *et al*. Process and impact of mergers of NHS trusts: multicentre case study and management cost analysis. *BMJ* 2002;**325**:246

Far from suggesting that cost is unimportant or that great care should not be taken with the allocation of precious resources, this scan has put together a number of sources that suggest economic rationality is not the dominant mindset for patients, clinicians, or managers and therefore it should not be assumed that the future of the NHS can be shaped by economic rationality alone. The NHS needs to better understand different ways of thinking. It is unlikely to meet the needs of the public and fulfil its expectations through economic proxies. The vision of an NHS that moves resources closer to patients, plans care more around their individual needs, and involves patients at every stage will fail if economic rationality alone is employed to shape behaviour.

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