The problem with rational approaches to reforming the NHS

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 cog is 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 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?

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Assumptions about the capacity of the PCG to achieve the greatest good for the greatest number might be informed by the finding that “the discourses 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”.


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 consumer driven 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 privacy of 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 decisive in the process of purchasing health care products. The problem is that this logic depends on consumers behaving as “rational, sovereign and decisive in the process of purchasing health care products”.

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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 their future health. As the following paper shows, these are not rationally motivated.

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.

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 overriding and 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 rendered, 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”.


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serious illness, which they are generally unwilling to plan for or even contemplate; secondly, a time when death is near and cer-
tain, 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
depth of 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".

▼ Knowing that there are limits to rationality is not especially
helpful. Doesn’t this lead to gridlock? A paper from Sweden
suggests a better understanding of different perspectives and
underlying motives might allow ways of incorpo-
rating 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 nec-
essary. "Obviously, some kind of priority order within the public
healthcare system has to be agreed on, but opting out 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 cli-
nicians, 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 similari-
ties 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 considera-
tions against the apparent suitability of the case for psychothera-
paeutic 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
psychotherapy. There were some similarities between the
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▼ A key insight presented by the papers is that rational calcu-
lations 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 health-
care 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 BJM
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
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All four cases of merger studied by the research team showed
"that the mergers had a negative effect on the delivery and devel-
opment 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”.

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 fulfill 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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