Is an NHS designed around the patient bad for your health?

Concern has been expressed that the current patient choice agenda that equates health-seeking behaviour with any other form of consumerism may not be in the best interests of the NHS.[1,2] An alternative viewpoint sees the role of doctor in a partnership with the patient, based not on power or patient choice but one of mutual respect. In this paper I examine the role of patient and healthcare professional from the perspective of the three basic organisational frameworks of hierarchies, markets and networks. It is concluded that the objective of any service reconfiguration should not be to correct the asymmetries between patient and doctor through market or bureaucratic means, but to build upon their differences in networks of trusting relationships and cultural norms that facilitate coordinated action. This approach will provide the most effective and responsive framework to the challenges that lie ahead.

HEALTH CARE AND THE PRINCIPAL–AGENT PROBLEM

Decision making in health care is characterised by two problems. Firstly the transfer process between healthcare inputs and health is often poorly understood, and physicians are required to make implicit decisions. Secondly, there is a knowledge asymmetry among stakeholders due to the specialised nature of medicine.

These problems have been interpreted within a 'principal–agent' framework. Here, the principal (the patient or healthcare organisation) delegates activities to an agent (the doctor), who is expected to accomplish these activities at the principal's behest. The focus of analysis is on how asymmetries of information and potential incongruent objectives between principal and agent can be minimised.[3] Hierarchies and markets have formed the two main approaches.

HIERARCHICAL ORGANISATIONAL MODELS

Hierarchies form the traditional model of organisational structure, where upper levels place constraints on lower levels. Each individual has a predetermined function operating in a bureaucratic system of rules and regulations. The contention is that the cost and consequences of alternative resource allocation patterns can be identified and explicit decisions made that are consistent within stated values.

This form of organisation is suitable for systems where outcomes are well defined and the transfer process that relates system inputs to outputs is understood. In this model agents operate within rule-based frameworks based on technically derived evidence and incur penalties if they deviated from within the defined structures.

MARKET ORGANISATIONAL MODELS

A market model is based on the principle that individuals are motivated by material self-interest and make rational and consistent decisions to this end in terms of their consequent effects. Each individual is best placed to judge their own welfare and the choice of activities that promote it. The welfare of society is composed of this sum of the individual welfare of the people within it.

From this perspective, market-based policies can alleviate the principal–agent problem by publishing indicators of agent's performance combined with greater patient choice. The early 1990s first saw the introduction of quasi market forces into the NHS and the notion of consumerism, with the separation of purchaser from provider, and the development of GP fund holding. However, measurable changes were small[4] in an environment that split professional allegiances, bewildered the public and caused considerable managerial conflict.

ACCOMMODATING THE BEST OF BOTH WORLDS — THE MYTH OF MODERNISATION

In 1997, a government white paper[5] outlined a new modernisation agenda that was to be consolidated 3 years later in a detailed *NHS Plan*.[6] The theoretical framework was underpinned by the argument that rigid hierarchical state structures operating in a bureaucratic system were incapable of fulfilling the diverse needs of society. Alternatively, markets, although providing an efficient distribution of resources, would not provide acceptable social outcomes. More fundamentally, the principal–agent problem was to be addressed by a combination approach.

A 'New Public Management' aimed to utilise the dynamics of markets but with the public interest in mind.[7] Clinical discretion was to be reigned-in within a scientific-bureaucratic framework[8] underpinned by guidelines and service frameworks, alongside a performance management that sought to direct behaviour through a system of punishments and incentives. The public availability of system performance data combined with the imposition of choice and competition were to provide the market drivers. The new mantra consolidated the patient as the central unit of government policy analysis — 'a vision of the health service designed around the patient'.[7]

However, despite some limited successes, the impact of policy initiatives introduced under the guise of a modernisation agenda has been disappointing, as strain is placed upon the system by a series of difficult balancing acts that the Modernisation movement demands.[9] Doctors are unhappier than ever[10] and patients have shown little interest in health service data, being more inclined to trust their own experience and those of friends and family.[11,12] The increasing array of targets and incentives can have a deleterious effect on performance, creating a range of unintended and dysfunctional consequences that can undermining the intrinsic motivation of the workforce.[13,14]

In reality, when confronted with the paradoxes and ambiguities of the new public management, healthcare organisations have adopted coping strategies, thereby reducing the gap between policy rhetoric and service reality and maintaining the illusion of an NHS that is both modern and dependable.

FROM BUREAUCRACIES AND MARKETS TO NETWORKS

The modernist tradition on which both markets and hierarchies are based views individuals as singular coherent selves, working in systems that can be understood by breaking them down into their

component parts and whose behaviour can be directed by an ever-expanding array of carrots and sticks to engineer the system to its desired state. Policy-makers and analysts fall into the trap of self-fulfilling policies as the dominant organisational discourse influences the choices and activities of the system, inducing through incentive structures the very behaviour they purport to predict and explain.

An alternative perspective, drawing upon the social constructionist literature, suggests that everything we know is created from the relationships we have with each other within the context of our prevailing culture.[15] This starting point offers an alternative approach to the principal–agent problem — fostering a greater congruence of goals between both parties within a network model of organisation. Network forms are likely to be advantageous when access to local information and tacit knowledge is important, where high levels of uncertainty exist about appropriate delivery strategies, and where joint production of health care across agencies is a dominant feature.[16]

A key feature for network success is a high level of interpersonal trust (the expectation that others will behave in predictable and desirable ways even in the absence of incentives or scrutiny). Trust is a prerequisite for cooperative behaviour and can reduce transaction and verification costs, improve communication and enhance teamwork.[17] Trust can also increase job satisfaction and commitment to the organisation, and can foster innovation and creative problem solving.[18] Social networks, trusting relationships and cultural norms that contribute to efficiency by facilitating coordinated action are known as social capital and are likely to be important factors of production in the delivery of important health and social outcomes.[16]

This alternative model sets the patient–healthcare professional relationship as the central unit of organisational analysis and accepts that there are nuances in this interaction that are important for the production of health, but that cannot be articulated within a scientific–bureaucratic framework. The emphasis is on the exchange of knowledge and negotiating of meaning in a network held together by commitment rather than an endless stream of policy directives focused on patient and healthcare worker as single units of analysis.

Although networks have been explored from within the disciplines of economics and sociology, the emerging science of non-linear systems or complexity theory is beginning to offer alternative insights, shifting the focus of attention to the inter-relationships between system parts and not the parts themselves or the outcomes they produce. All elements are co-evolving in a network that is continually transforming itself.

Although beyond the scope of this text, complex non-linear networks have a number of important characteristics. For example, small changes in one part of the system can have large and unanticipated consequences elsewhere, and rarely is there a simple relationship between cause and effect. A complex system cannot be understood by a reduction into its component parts — what an organisation becomes emerges from the relationships of its members who can self-organise into a configuration that satisfies the constraints placed upon them without external direction. The emphasis moves away from prediction and control to the configuration of relationships among a system's components and an understanding of what creates patterns of order and behaviour among them.[19] This has a wide range of insights and implications for health service delivery and planning.[20]

CONCLUSION

It is important not to overlook the ever-present potential for human disinginuity. All systems need a degree of regulation and the trick is to get the right balance between checking and trusting.[21] A more effective approach to the principal–agent problem is not to view the patient as consumer but to encourage health systems to evolve on the basis of the shared experience of all stakeholders with an emphasis on learning from each other.[22] To recognise a socially constructed world that can accommodate goal-seeking behaviour but is cogniscent of the importance of network, history, relationships, culture and aspirations. The policy objective is to develop a conversational competence among stakeholders building upon the existing cultural strengths of the organisation, rather than the current emphasis of an increasingly scientific and methodologically-driven outcome focus based on single independent elements.

Unfortunately, the social and professional networks of trust and the norms of reciprocity that these developments require have been neglected during the years of organisational change. This neglect will be further accelerated by a focus on a patient-centred NHS. For the vision of the NHS to succeed, we need to recognise that, ultimately, health emerges from the relationships we have with each other and that the fundamental unit and starting point of any organisational analysis must be the correct one.

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