Present dangers and future threats: some perverse incentives in the NHS reforms

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The NHS reforms have come to mean all things to all men (and women). Identifying a market oriented purchaser-provider split as the conceptual heart of the reforms is still, however, useful. There are important perverse incentives in and around the NHS that are associated with the reforms; furthermore, many reactions to the resulting problems are paradoxical and often counterproductive. Hitherto most criticism of the reforms from the health policy and management community (as opposed to the professions and the public) has been tactical rather than fundamental. There are serious problems for the NHS associated both with the NHS market and with current, often tacit, strategies for the future of the service.

There are paradoxes and perverse incentives associated with the NHS reforms. The paradoxes concern reactions to current trends; the perverse incentives flow from many of the mechanisms and structures created in the NHS since 1991.

It is increasingly taken as axiomatic that the "purchaser-provider split" is a good thing. Criticism of the NHS reforms by policy analysts is thus usually tactical rather than fundamental. It might emphasise, for example, inadequate coordination in purchasing[1]; a tendency by the government to muddle through rather than act strategically[2]; or the inadequate attention paid to appropriate outcomes and the inadequate or inappropriate uses that information is put to.[3] But these relatively gentle critiques ignore problems that stem from the heart of the reforms. Several of these problems are increasingly of concern.

Perverse incentives

Evidence for my comments on perverse incentives comes partly from confidential interviews conducted during 1993-4 with chief executives and board members of health trusts, health authorities, and health commissions; clinical directors; and business managers. Naturally the phenomena noted cannot be proved to be part of a uniform picture, and indeed research that links cause and effect in a complex field of policy is fraught with basic difficulties, both conceptual and methodological. Nevertheless, the following practices can clearly be identified as dangers; whether trends will continue in the same direction depends on whether national policymakers react more than cosmetically to such dangers.

PASSING THE BUCK

The purchaser-provider split is often used as a mechanism by which purchasers pass the buck. Increasingly under pressure from the government's ever tighter agenda based on squeezing more output from less money, purchasers can now say to their main providers: "We have the money; but it's you who run the services. So here's the cash; here's our long list of requirements. Don't complain to us if you can't manage within the money. We're safe in the knowledge that it's hospitals to which the public complains."

The purchasers who wish to work closely with providers to avoid this temptation in effect end up jointly planning the service with providers—all very well, but the antithesis of the behaviour advocated with the reforms. Moreover, moving away from block contracts is unlikely to occur to such an extent that would clarify what can reasonably be expected of providers. For the Department of Health is speaking with a forked tongue on this issue: the more that contracts quantify cost, volume, and cases, the more that rationing is overt and the more that the limits of existing finance are seen to block the government's desire to increase output beyond what is reasonably possible. Moreover, the more detailed contracting that is required in cost-volume and cost per case contracts increases management costs—which is accentuated by the move to more widespread general practice fundholding.[4] Such costs can only be recouped by cutting the number and income of front line staff—or by arbitrary interventions by politicians to "cut management costs."

SHIFTING COSTS

Hospital and community trusts are increasingly seeking to shift costs—that is, patients—on to each other. The purchaser-provider split is encouraging providers to vie against each other as well as against purchasers. Additionally, attempts by purchasers to regulate this situation are falling victim to short-termism. For example, purchasers are making contracts with community providers for acute care, and community providers who pay doctors by the session are winning the tenders. But these deals pull the rug from under hospitals, which face fixed costs (and the major service costs of the medical profession) yet less activity and income. All in all, the aspiration of "seamless care" between hospitals and community services is undermined by such behaviour.

BACKDOOR PLANNING

General practice fundholding is threatening both hospitals' ability to plan and regional offices' strategies for rationalising services to increase value for money and the total productivity of the system. Thus backdoor planning has to be undertaken at a regional level to coordinate purchasing on an area basis (euphemistically called market management) and indeed to scale the wall that stands between purchasers and providers. Yet the transaction costs (the costs of mediating this rather than planning it) are likely to be high, and the legitimacy of the system is undermined as covert rather than overt action is necessary to ensure the system works. Even more seriously, some general practitioners are seeking to use the market to lure NHS consultants to do work in private hospitals. This would mean that consultants would be competing with themselves, as part of the NHS tender.

MARKETING INTERFERES WITH NEEDS

A combination of frenetic marketing by trusts (to both fundholding and non-fundholding general practices to try to steer district contracts their way) and disaggregated purchasing is leading to radical uncertainty in hospitals. Protecting appropriate centres of

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excellence, specialised services, and indeed appropriate local services becomes much more difficult—and again becomes a backdoor exercise by the regions.

Furthermore, to the extent that marketing by providers takes on a dynamic of its own, it has the capacity to subvert purchasing plans based on needs. The "culture of contentment"[5] may mean that the priorities of the wealthier electoral majority can more easily dominate in a fragmented health care system, where the scope for direct marketing to the articulate public will constrain purchasers.

EMERGENCY CASES

Given that, logically, the essence of the reforms is to replace reimbursement of referred patients using public money with contracts whereby the patient follows the money—except for in emergency cases—the incentive is to reclassify patients as emergencies (compounded by fundholders' attempts to shift costs by getting emergency cases out of their budgets).

THE COST OF PRODUCTIVITY GAINS

The transaction costs of the reforms are high enough that such costs have to be recouped through greater "productivity," which often means exploitation rather than efficiency. The so called productivity gains of the reforms are at least in part due to the extraction of surplus value from both workers and managers, who work longer hours more intensely without reward. Just as Karl Marx is pronounced dead throughout the world, Mrs Bottomley has him turning in his grave.

LACK OF LOCAL CHOICE

The domination of national productivity over local choice (questions in parliament are best answered by statistics about national productivity) means that the argument that the culture of purchasing is more sensitive to local needs is mostly hype. Neither services nor their locations are being chosen by patients or the public on any important scale. Many commentators naïvely add to this, "yet," without seeing that the engine at the heart of the changes makes it less likely in the future. Regions (already acting as regional offices) have to "plan the market"—that is, squeeze more acute care out of less money and produce a shift to primary care out of existing budgets. In this context communication with the public means public relations on behalf of the inevitable. Of course this is not the official role of regions. But in practice they have to intervene to influence purchasers. The tight accountability of purchasers to the new regional offices (part of the Department of Health and its NHS Executive) makes both political and managerial control more likely and more centralist.

THE COST OF ACUTE CARE IN THE COMMUNITY

The shift to primary care is in fact a move to acute care in the community. The degree of pressure that this will put on general practices and community services is currently unknown, but such a move has the potential to make the debacle of unfunded community care seem a gentle apéritif by comparison. The aim is presumably to prevent expensive admissions to hospital—for example, by more effective treatment of chronic disease. The problem here is that effective, consultant based outreach clinics in the community are expensive and time consuming. (One consultant has estimated that for eight patients seen at an outreach clinic he could see 70 in the hospital.) At a time of increased pressure in hospitals because of tighter funding, the "new deal" for junior doctors, and, soon, the consequences of the Calman report, such policies may have a high opportunity cost.

The other element of community based care may in theory concern the care of elderly patients with non-acute conditions and others previously known as priority groups. Indeed an original defence of the reforms was made by Ham on the grounds that the purchaser-provider split had to be retained to ensure that a community and priority focused NHS was allowed to develop.[6] Yet nearly three years on, the priorities are often being jettisoned altogether—and the causes of, for example, health inequalities are increasing.[7]

Paradoxes

CONTRADICTIONS OF THE "MANAGED MARKET"

The "market" is in fact becoming a place where hospitals must tender competitively to survive, not a mechanism by which money follows the patient. A "managed market" is an oxymoron. Inevitably, in our centralised culture, management by regional offices will supersede any market recognisable by health economist Alain Enthoven. This may even be desirable, albeit hypocritical and deliberate if done by the present government. But desirable or not, winners and losers are being planned by regions, and mergers and closures too. Why then, at the "sharp end," does a fierce market seems to be operating?

The paradox is explained by the fact that only a middle tier of hospitals and services is actually competing openly (as much for regional "waiting list" monies as for purchasers' business). The other hospitals and services are marketing themselves to achieve expected targets. When the planned shake out of hospital beds has occurred there will be even less scope for a market. Thus the market is a transitional device, not a long term feature. After all, the hospital market tends to be a monopoly, arguably more than most markets; and paradoxically only expensive regulation can preserve the trappings of a market in the long run (by which time the appropriate scale and location of services exists, raising the question of why we should bother with a market anyway).

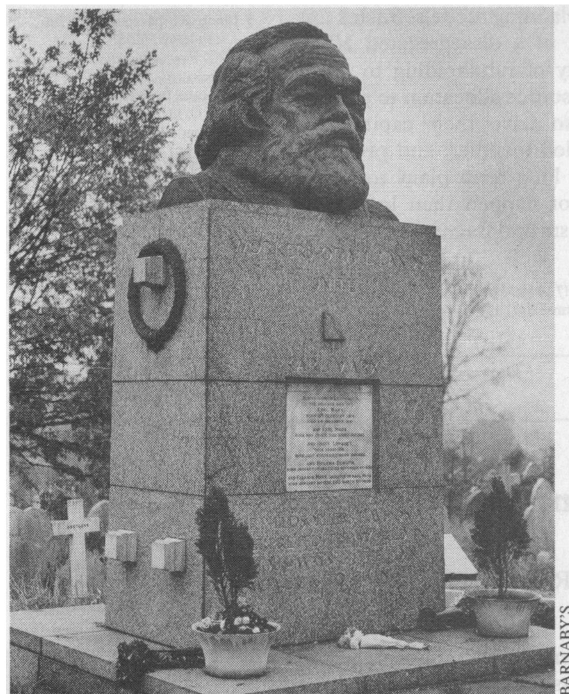
Public finance for publicly planned services is both more efficient and more equitable, as international experience teaches us. But since the government is forced by its own ideological agenda to apologise for this rather than proclaim it, it is also forced to be defensive when confronted by ultra-right wing ideas advocating greater privatisation and more cut throat markets.

LIMITATIONS OF THE MANAGED MARKET

Since vying for contracts, as the result of an uncoordinated purchaser-provider split, is at the heart of the problems engendered by the reforms, why are long respected managers now advocating even more autonomy and commercialisation for hospitals? The reason lies in the oxymoron of the managed market—the limitations are now evident. The choice is either more privatisation or more effective management of the system—without much of the unhelpful rhetoric about markets. But the second option is the truth which dare not speak its name.

PURCHASER-PROVIDER SPLIT COULD DEEPEN

In the light of the need for greater coordination of services and secure financing for the NHS, it is ironic to see left of centre groups advocating that local government should take over health care.[8] In 1948 doctors preferred Bevan's national model, as direct control of hospitals by local politicians was considered highly unappealing. Some argue now that purchasing by local government is more possible politically—without intense opposition from the medical profession—as a result of the purchaser-provider split: hospitals would not be controlled by local government. But to enable this hospitals and services would have to be



BARNABY'S

Karl Marx would turn in his grave at the exploitation of NHS workers to achieve greater "productivity"

separated from the local government purchasers even more fundamentally than they are from health service purchasers. Thus ironically the purchaser-provider split would probably deepen and certainly become institutionalised in a rigid way, whereas the sensible challenge is to preserve the distinction but not the institutional split, which has actually proved harmful in a number of important ways as described above.

Furthermore, local councils would be conservative in protecting local hospitals even when regional centres of excellence were a better way forward. As a result, advocates of an NHS purchased by local government often advocate a separate acute service, funded centrally, with local government concentrating on public health.[8] A huge irony, however, exists here. The advocates of such a way forward would be responsible for more fragmentation than at any time since 1974, or arguably since 1948.

Financing the NHS would become subject to the tortuous and politicised financial wrangles between central and local government, and inequity between rich and poor councils would grow as the scope for a formula for a national resource allocation was diminished. Currently, reasonably objective measures of need are used to allocate resources to health authorities, and recent work is seeking to improve these measures,[9] although the official response is less clear.[10] (One of the reasons may be the difficulty in allocating equitably to fundholding general practices.) While some local choice would be increased by giving budgets to elected local governmental authorities, central government would have to give money to poorer areas. But such grants would either be dependent on central definitions of need or be subject to a complex formula for "revenue equalisation," which would be difficult both economically and politically. General reflection on and actual experience in the United States with revenue equalisation (between federal, state, and local governments) suggest that it is difficult to tax richer areas for the spending in poorer areas in ringfenced policy arenas. For example, area 1's decision to spend compels area 2 to subsidise area 1 (if area 1 is poor with less local tax base and greater (locally defined) need). Admittedly, such subsidy is limited to the total pool of money generated, which ceases when the poorer area is subsidised so that the richer area then has to raise taxes at an equally high level. The only alternative is for central government to find the money—this would be unlikely to happen on an equitable basis, especially if central government disagrees with the local definition of need.

Certainly a clearer strategy is needed for health promotion, involving policies on housing, transport, education, social services, and, especially, elimination of poverty. But we also need a "cure and care" NHS. Creating one agency responsible for all health care would make it politically easier, paradoxically, to diminish the total budget for health services and public spending relevant to health. That is because when spending is less specifically ascribed to functions, one global budget can be cut less visibly and responsibility for making cuts devolved more. There is a need both to prevent ill health when possible (through broader social policy) and to cure and care. It is as well to recognise this institutionally.

IDEOLOGICAL ANSWER TO PRACTICAL PROBLEM

When so much needs to be improved it is paradoxical that sceptics who scent trouble on the road ahead are confronted by the fatalism that says, "whatever the current situation, no future government should make much change." At one level this is understandable. Managers and professionals are suffering from an iatrogenic disease known as initiative fatigue; and the irony, not lost on the Conservatives, is that a lot of harmful change makes changing back or further change less tolerable, even if it is desirable.

But the challenge is to improve and recoordinate the NHS without either huge structural reorganisation or simply a return to 1979. The reforms actually consisted of an ideological answer to a practical problem. And now the ideology is of little practical help. That is why commentators who argued in 1994 that the government was drifting were right—but almost to the point of banality.[2] Such commentators, however, were not perceptive enough to see that a conspiracy was emerging to use the state of flux created by the reforms to impose ever tighter productivity requirements on the NHS and to steer the NHS away from comprehensive goals without public debate. In this context the recent British apology for a debate about distinguishing health and social care contrasts with Scandinavian attempts to create consensus through open debate.

The NHS has been used increasingly as a surrogate for broader measures in social policy that might help to reverse increasing inequalities in health between social classes and cohorts. It is the NHS that increasingly has to "carry the can" in prevention and promotion, as well as in cure and care. This inevitably leads to a focus on individual (rather than social and environmental) causes of ill health—convenient for the government, but another example of passing the buck.[11]

Conclusion

The original practical problem of the 1980s health service should be readdressed in a practical way: how can providers be rewarded for appropriate workload, planned on the basis of communities' needs, within available resources? That certainly requires more sensitive commissioning, but not necessarily a market. There is now scope to diminish the costs of the malfunctioning market and use the dividend to invest in better services. Creative and positive developments in today's NHS—and there are many—stem from factors distinct from the market.

Such developments can best be created by investing both in egalitarian and "pro-health" economic and social policy and in a more generous cure and care NHS. Structural change is only part of the story in providing effective health care—and better health—but it is important none the less. Planning services on the basis of need requires a close link between methods

of resource allocation and planning models. Such a link is in danger of being lost in a disaggregated NHS, especially with the capacity of fundholding to dilute systematic and equitable resource allocation to populations. Services should also have their capital and revenue requirements funded together; and providers should be accountable for long term plans to health authorities. If this does not happen then long term benefit is lost in short-termism and fragmentation.

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How To Do It

Doctor on a mountaineering expedition

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Doctors are welcome members on mountaineering expeditions to remote areas, but practical advice on how to prepare and what kit to take can be difficult to find. This article is a ragbag of useful advice on diverse topics. It explains the necessary preparation, provides tips for a healthy expedition, and summarises the common disorders encountered at high altitude. The comprehensive drug and equipment lists and first aid kit for climbers were used for the 1992 Everest in winter expedition. They are there to be sacrificed to personal preference and the experience and size of individual expeditions.

An offer to be the doctor on a high altitude expedition presents exciting opportunities for travel to remote areas, but practical advice can be difficult to find. In this article we offer guidelines based on our experience from large and small expeditions lasting up to three months to the Andes, Alaska, the Arctic, and Everest in winter.

Preparing for the expedition

COMMUNICATING WITH EXPEDITION MEMBERS

Write to expedition members in good time with advice on vaccination. Full courses of hepatitis A, hepatitis B, or rabies vaccine take seven months, while booster typhoid, tetanus, poliomyelitis, or meningococcal vaccine or hepatitis A immunoglobulin should be given more than two weeks before departure. Specific advice on malaria prophylaxis and vaccination can be obtained from the Travel Clinic, Battenburg Avenue, North End, Portsmouth (telephone 01705 664235) or the Hospital for Tropical Diseases in London (0171 387 4411) or Liverpool (0151 708 9393).

Issue a brief questionnaire about previous medical history, particularly asthma, peptic ulcer, diabetes, and heart disease. Do not assume good health, especially if friends or relatives of the expedition members are joining the trek to base camp. Advise members to have a pre-expedition dental check up, since a lost filling or dental abscess challenges doctors with no dental experience. Ensure members have medical insurance to cover the costs of treatment and recovery to Britain.

ASSESSING LOCAL FACILITIES

Contact doctors who have previously travelled in the region. Names of doctors are usually discovered by word of mouth, but they may be obtained from reports published in journals of the Alpine Club or Royal

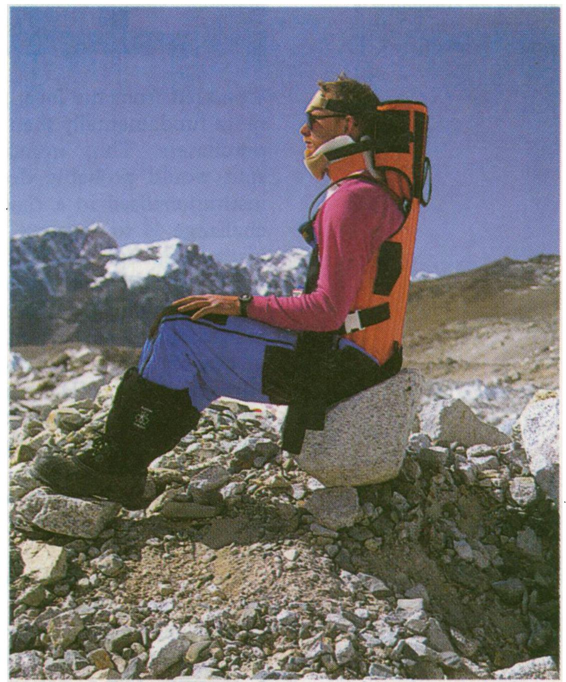

FIGURE 1—*Testing KED spinal splint and Stifneck cervical collar at Everest base camp*

Geographical Society. Alternatively, write to the British Embassy or High Commission in the area through the Foreign and Commonwealth Office. Voluntary rescue organisations are a good source of information (for example, Himalayan Rescue Association, PO Box 495, Thamel, Kathmandu).

Determine the options for evacuating a casualty (helicopter, yak, mule, stretcher, etc). Helicopters have an absolute altitude ceiling depending on the aircraft, season, weather, and load to be carried—for example, Everest base camp (5400 m) is inaccessible to helicopters in winter, but in summer one unaccompanied casualty can be evacuated. There may be little alternative but to try to provide independent resuscitation and treatment facilities. Establish methods of summoning assistance (radio or runner) and for carrying casualties, either with a dedicated stretcher (such as Beacons stretcher, Functional Foam, Powys—telephone 01685 350011) or one improvised from expedition equipment. Spinal injuries, which are an appreciable risk in mountaineering accidents, need special care; the Ferno KED extraction device and Stifneck cervical collar are suitable (fig 1). Recovery to

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