Chapter Six: The importance of monitoring ends and not only means – choice, competition, efficiency, innovation and regulation, in health care

Ever since the principles of general management were introduced into the NHS by Roy Griffiths in the mid 1980s and followed a few years later by the quasi market, health care professionals have protested that health care is so different from other service industries that it should not be subject to the same management practices, nor to the same assumptions about its underlying dynamics. While these claims have been largely dismissed (with a little justice) as self interested, naïve or ignorant, there are indeed real and important differences.

In this chapter we look carefully at how the concepts of efficiency, choice, competition and innovation are described, how they are enacted and at the consequences when they are. We go on to discuss the very great importance of keeping in mind the ends we are trying to achieve and not only the means we have chosen to take us there.

Choice

Choice is a word that sounds wholly benign. It suggests we are offered a range of options and can choose freely between them the one that most meets our needs or tickles our fancy. As a result of our choices some goods and services fare well in the market and are developed further, and others do not and are discontinued. In this way resources move to where they are best used, quality rises and prices fall.

Thus customers offered options feel (and have) a greater sense of control than those who are not, and the efforts made by customers in comparing these offerings are translated into higher quality, lower cost products.

This is the rational background against which choice and competition, combined with regulation, are advocated as the way we increase quality and decrease costs in health care. The extent to which this is being pressed into service may not be fully appreciated by some of those involved. One Medical Director of a PCT was surprised that when he raised concerns about the quality of care in a local hospital surgical service with the Director of Commissioning, the latter's response was that since patients now had a choice and could go elsewhere the quality was no longer a Commissioning concern.

If we think carefully about this instance we might suggest that, for a choice of this sort to be meaningful, patients would need to know enough about the quality of different services to be able to make an initial choice, understand and afford the consequences of that choice

(e.g. increased travelling time for themselves and their families) and be able to change their choice midway through their experience if they find it unsatisfactory. Furthermore that they fully understand all the consequences of that choice – for example that they may be unable to access local physiotherapy services on discharge but have to travel to those attached to the hospital they chose instead. As James Harrison[1] notes 'these seem big assumptions, not least for the weakest who need the most protection'.

This is an oddity. A concept that sounds as though it is conferring a benefit on the patient (you don't have to go here, you have a choice of there and there as well) is instead being used for the benefit of commissioners. They now do not have to engage in that most difficult of tasks: ensuring that clinicians are encouraged to review and improve their service. Instead they can leave it to 'choice and competition'.[2]It is surprising how often this happens in the NHS –that a term that seems beneficial for patients turns out in practice to be the opposite. We will look at other examples shortly.

Choice has been considered by some interesting and eminent reviewers, so let us look at what they have concluded.

Amartya Sen argues that instead of being fetishistic about freedom of choice we should ask if it nourishes or deprives us, makes us mobile or hems us in, enhances self respect or diminishes it, enables us to participate in our communities or prevents us. Increasing choice among goods and services may not add to any of these, indeed it may impair our freedom in that it steals the time and energy that we need to put into choices that do contribute to these.

Rowan Williams observes that by making one choice we close off another, and that we are changed by our choices and can't revert to what or where we were before. This is especially true when those choices involve education or health care. Furthermore the very fact of having these choices changes society. Choice in education is increasing inequality. 'Wanting what is best for the growing generation' is not the same, he is surely right to argue, as 'wanting what is best for my child', and giving individual choice leads to a loss of corporate responsibility in education: a 'shared responsibility of inducting children into a social environment with at least some common values and the providing of what is needed to understand and question that environment in terms of its success in embodying those values'.

Furthermore, choice does not always even feel like a good thing: Barry Schwartz writes of the 'tyranny of choice', citing research that people are happier with the chocolate they

[1] A member of the learning set whose paper on choice is the basis for this section.

[2] Making the assumption that hospital managers will see the need to encourage their clinicians to do so – but we have been here before – see Chapter One.

choose when given choice of three chocolates than when confronted with a choice of 20. He argues that while we embrace choice in that it gives us control over our lives that we wouldn't have without it, 'just because some choice is good does not mean that more choice is better'.

Indeed when we think about it, can we be sure that the options available to us in health care can be described in terms that are meaningful to the chooser? The indicators available about different care providers do not reflect in any way what *being* there will feel like, and nor they do give clear indications of which option will achieve superior clinical outcomes for the chooser (even if they can for 100 patients allocated the same diagnosis they cannot for an individual). Thus GPs report that patients usually ask which they, the doctor, would choose, and they sometimes see this as childlikeness on the part of patients. It is however an indication that patients do not know *how* to choose, and that they believe the doctor will know more about the options and about how to make that choice than they themselves do. If we think about this more carefully we can see that this kind of choice is either terrifying or meaningless. If it is a choice that is a matter of life or death, better or worse clinical outcomes, then that is surely a terrifying responsibility for people with no clinical knowledge. If it is a question of whether the bedside phones are provided by operator X or Y then that is of so little consequence as to be meaningless. If we are to be given choice let us have an honest debate about what aspects we want to be able to choose.

It has been said, and often, that the public do not want choice, they want the local hospital or school to be good (and as good as any other). But then we need to ask the question: how do we ensure that every local hospital IS good? If the argument is that the effort that goes into making that kind of choice translates into good services for all then we could ask the question: if the public do have to make some effort if every local hospital is to be good, what kind of efforts are we prepared to make? If we put it that way we could have a good debate about it, consider what other options there are and choose between them.[3]

One of the options we might devise could involve finding ways of generating some form of local pressure informed by real experiences and by an understanding of the options and approaches available elsewhere.

How? A committee? (oh no!). No really not. Giving patient representatives the responsibility of making decisions on behalf of all patients is lazy and crazy. What is needed is really credible meaningful information, perhaps serious, in-depth feedback from patients after every encounter with services about what it was like to be a patient and about the kind of details that enhanced or diminished the care they received. Routine follow up from

[3] After all there is a lack of internal logic if we have no choice about whether we have choice.

independent researchers could provide rich, multi faceted, useful information in a way that the current patient surveys simply do not.[4]

Such an exercise would need to be combined with some means of finding out how services had used this information, and perhaps this could take the form of a carefully considered report,[5] by an independent body, of what people have said and how the service has responded. The public could then take an interest in this and discuss it (both rationally and emotionally), in a number of different forums.

But this is only one idea. Exactly what could be done to make the most effective use of the time and energy of patients and public could only be devised (and revised and re-envisaged) over time, and there will be many who talk of apathy and the difficulties of involving more people than a few activists. There is considerable electoral evidence however that very many people care deeply about the NHS, so finding a way of tapping into their support must be possible, but only once we decide to re-take responsibility for quality and costs and not leave them to processes like choice and competition. Another way of describing this is to remember our definition of care (acts of work or courage in pursuit of flourishing) and use it to find ways of helping people who care about the NHS to do so. This is so much more exciting and liberating and has so much more potential than the imposition of choice and competition in the belief that it will, magically, result in better and cheaper care.

So choice is important, even essential, but the choice that is important is that about how we ensure that care is of good quality and is affordable, choice is not an end in itself.

Competition

The value of competition is that it energises, it increases creativity and reflection and leads to better ways of doing things, or cheaper, or ways that are both better and cheaper.

Well sometimes it does this. Or rather: some kinds of competition do this. The kind of competition that yields good results is where I look over my shoulder at any rivals, notice what they are doing, and think 'oh is that what they are doing, I could do that, in fact I could do better than that, let me see…' Or 'oh I hadn't thought of that' or 'oh are they reviewing that aspect of care? What would we find if *we* did?'

[4] This is done routinely some fortnight after discharge for many Not For Profit hospitals in the US. Discussed with CEOs from NFP hospitals at an ODPN seminar in 2006

[5] Many will protest that this (or something like it) is already being done. And indeed there are transactional variants of this aplenty, all devised with good intentions but ensnared in the management method. For this to be real we need a different kind of dialogue

Many kinds of competition do not lead to this. Instead they lead to concentration of power and assets, 'winner takes all' market domination, protectionism, risk aversion, increasing bureaucracy about tendering for contracts etc etc and results in an *increase* in costs *overall*.

In a cash limited service of vital importance increasing overall costs in this way is, clearly, a matter of great concern. It takes money away from *real* things and diverts it into these paper trails, tendering processes, back covering, and other unproductive activities. Worse, it leads to a race to the bottom, in which, for example, NICE guidelines become not a baseline but an upper limit.

So we need to ask the question: in the NHS what would a good level or type of competition look like?

Do we need it at all? Well we need something to 'keep us honest', by which I mean steer us away from complacency, arrogance and waste. But we need to be clear what it needs to keep us honest about, and that is *reflecting on our performance, reviewing the quality of the services we offer, challenging ourselves and each other to perform better and to design services that are better and cheaper.* To do *that* we need to be doing the sort of things we described in Chapter One: supporting, enabling and challenging everyone involved, including high status individuals and groups who are mostly untouched by the pressures of competition.[6]

In other words, it isn't competition that works it's this: supporting, enabling and challenging. Competition is only the means of getting to this, it's not an end in itself. Economists will tell you that competition leads to the four Is: innovation, information, investment and incentive,[7] and you can tell this is economist speak because it is so depersonalised. If we put people back in then it is about people choosing to innovate, people receiving and acting upon information about the quality of their services compared with others, people choosing to invest in areas that will yield a better return, people receiving rewards for efforts they make. Put that way we could suggest that the kind of quasi market we have in health care does not in fact produce these features and we could usefully design the competition we build into our system so that it does do this, not more and not less. Thus competition that is healthy and productive should look different in different industries and the different settings within them and we should be suspicious of any attempts to introduce a particular kind of competition just because it is perceived to be successful elsewhere.[8]

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[6] Are we really going to get rid of a highly specialist consultant it has cost millions to train? When it comes to a standoff? However vituperative the discussions at the time the consultants are much more likely to be working in similar ways with similar patients 1-2 years later than are the managers who berate them to be in their same job.

[7] See for example Peter Jay's Road to Riches

[8] E.g. utility industries

While we are talking about economic perspectives on competition in health care we should not ignore Michael Porter's analysis that competition in health care (in the US anyway) is not working because it is too broad (the competition is between hospitals and not between, e.g., urology services), too narrow (it involves only part of the pathway) and too local (services should be able to compete for custom over a wider geographic area, leading to centres of real excellence). Our argument about the kind of competition Porter advocates is, again, that there is nothing about it that will lead inevitably to the reflection needed. It could easily lead to major centres in which clinicians are protected from the need to reflect by the size of the budgets available to buy the new kit that will appeal to patients.

But is not only that unhealthy competition does not lead to better care (because it does not lead to the reflection and review that would deliver better care) but, worse still, it will be reflected in bad behaviours at all levels of the system. Complexity theorists with their understanding of fractals[9] would predict not only competition between organisations but stressful competition between patients, between practitioners, between services, even between health care systems (for example the NHS stealing staff from around the world).

Once again we have a word with benign connotations enacted in a way that delivers unhealthy consequences.

Efficiency

When you are making baked beans efficiency is great. We want beans that are healthy and tasty and cheap, we don't want any resource to be wasted in their production because that would increase the cost. And in health care we also don't want to increase the cost so we also want to avoid any waste.

To ensure this we talk of the importance of doing the right thing at the right time in the right place in the right way. And doing the right thing at the right time in the right way in the right place sounds great, indeed one would be thought disagreeable, if not perverse, to protest. But it makes a major assumption: that we know what 'right' is. And behind that assumption lies another: that there is such a thing as 'right'. But very often there is no single 'right' answer or approach. There might be a best. Or a better and a worse, and it is often more helpful to think in terms of those. More or less compassionate can sometimes be more helpful still.

The 'better' way to care for someone may involve giving them time. Or close attention. And to time and motion experts the first will look inefficient and the second will be invisible.

[9] Fractals: the behaviour found at one level of a complex adaptive system replicates behaviours found at every other level. So if we introduce competition at one level (between organisations) we will eventually find it at every other level, including between patients, as well.

Because these efficiency experts are looking for something that is not health care. What they are interested in are things like: How many people had their dressings changed? How long did it take? Could they have been done quicker or cheaper? How are people being given information? Are there quicker or cheaper ways of doing so?

But the outcome we care about isn't the speed of the dressing and how many dressings, or that people are given information; it is that a patient (a person) becomes reassured, and on a path to recovery at a time when they may feel vulnerable and unsure. And if that is our outcome then to see how efficiently we are achieving it we will have to find different ways of measuring.

Of course we must not waste money, we must make sure it is used wisely, and we could even call that using it efficiently – but only if we can agree on what our desired outcomes are.[10] If we could do that then we could indeed think about the most efficient way of getting there. As we did so, we might find that we have to turn some current assumptions on their heads. If we saw our outcomes as including patients' confidence in their treatment and their care giver, then we might find that, for example, rather than reducing skill mix as we have done for years , we should enrich it again.[11]

In other words: if we are to be 'efficient' we need always to keep in mind our ultimate purpose. In health care it is sometimes the case that both the purpose and the processes that will lead us to that purpose are clear. In these cases (in the domain of the known – see Chapter Four) efficiency is a concept that can be helpful.

Often the desired outcomes are multiple and to some extent individual, and are more 'fuzzy' – they can be articulated but not easily measured. In the domain of complexity efficiency is not a concept that is helpful. Nor is 'productivity'. 'Wise use of resources' is language much more likely to prompt the reflection and redesign that will yield results.

What does a focus on efficiency lead to?

- Skill mix reviews where we look at what people DO, not how they are thinking and what knowledge based judgements and practical wisdom they are using that inform what it is they do.

- A transfer of cost from provider to customer. Think, for example, about train companies. Once upon a time you could buy tickets on the train, thus turning up at the station with just enough time to catch your train. To be more efficient the train companies cut back

[10] This is a point well understood by academic economists but to their foot soldiers, local performance managers, it is not so clear.

[11] Not at greater expense. There is an argument that replacing two health care assistants with one nurse not only leads to better care but costs less. This is of course the converse of the argument often used.

on ticket inspectors on the trains and made it a fineable offence to travel without a ticket. Now you have to arrive at the station with enough time to join the queue at the ticket office or machine to buy your ticket. That is a direct transfer of cost from them to you. This isn't efficiency it is theft.

- A belief that you can take money out of a service without losing anything of value. At dinner a Director of Social Services was heard to boast that he was he was able, through commissioning, year after year to take money out of his services and achieve the same results – apparently completely ignorant of the enormous impact this had on the staff and clients of the voluntary sector organisations he bought them from. The fact that the consequences of this kind of action do not show immediately does not mean there are none, as BP and the water companies and many more organisations have all found out,[12] and unless they are taken very seriously the values of the commissioner can be conveniently ignored when contract decisions are made.[13]

- A belief that the private sector is better at managing resources than is the public sector.

Since this is a widely held belief (that the private sector is better at managing resources) let us look again at a concept introduced briefly in Chapter One.

Many private sector organisations ensure they harness resources efficiently (maximize productivity) by using four approaches:

1. *cuts* – they make sure they cut out unnecessary expenditure and in some cases cut out customers they cannot serve profitably
2. *rationalisation* – they rationalise production from several facilities into one, *realising* all the synergy that they can. In health care we would call that reconfiguration
3. *redesign* – individuals and teams work together to redesign flows and processes so that they are as efficient and customer focused as possible
4. *reflection* – individuals and teams reflect on their own performance on an ongoing basis to see how they can improve it.

All four of these methods can be (and are) used because staff can be incentivised and required to do all four, in other words they are part of a *connected* hierarchy.

In a hierarchy that is *disconnected* staff cannot be *required* to engage in these and *incentivising* them to do so is difficult (because the things they value are not in the gift of managers, e.g. papers and citations in prestigious peer reviewed journals, the regard of renowned peers). Thus in a disconnected hierarchy efficiency is pursued by means of only

[12] As described by many observers including for example Anthony Hilton in the London Evening Standard.

[13] Have you checked the terms and conditions of the people actually providing your patient transport now that these services have been contracted out? Minimum wage and no pension is not unheard of. While the Trust manager who negotiated that deal may congratulate him or herself on a great deal it feels like stealing from the most vulnerable.

the top two options (cuts and rationalisation). This is a pity since these will produce only one-off savings – it is the other two forms that yield ongoing productivity improvements.

So it is not the ownership that matters (public, private or social enterprise[14]), it is whether the hierarchy is (or can be) connected or whether it is important that it is disconnected. A misunderstanding of this is often what leads to the charge of 'cherry picking', when NHS professionals look at the work of independent sector providers. These latter offer good and efficient care in the sort of cases that lend themselves to protocols. Professionals here are operating in the domain of the known (Chapter Four), the leadership can be 'feudal', in other words it is clear what is the most appropriate pathway and everyone is happy to agree to this. The hierarchy is effectively connected.

In more complex cases where professional judgement and practical wisdom are needed It will be important to allow professions to 'muddle through elegantly' amending decisions in light of events as they unfold. Here the hierarchy will be disconnected.

Those making the charge of cherry picking have a valid case, or would do if in their own practice they distinguished between cases that could be efficiently systematised and expedited and those that required their professional judgement. They would then be able to compete for the cases that benefit from stream lined protocols and rapid throughput and retain their ability to offer a different kind of care in cases that require the exercise of their professional judgement.

So it is not the ownership that makes a difference , it is a firm commitment to good outcomes and to wise use of resources and the ability to work constructively with (i.e. support, enable and challenge) high status professions. This can be found (or not) in all three sectors: private, public and voluntary.

Just as an experiment to end this reflection on efficiency compare these two questions: 'What is the most compassionate use of this money?' and 'What is the most efficient use of this money?'

As you do, make sure you think widely enough about compassion: the most compassionate use will yield care that meets the needs of the greatest number of people. Compassion is a response to an understanding of the needs of others. So, to increase compassion and therefore reflection, redesign and innovation towards better and cheaper care, we must help HCPs to understand more about those who need their care, what those needs are, and the impact of the processes of care on their lives. An emphasis on compassion can motivate

[14] The rhetoric abounding in the current enthusiasm for social enterprises insists that since every member of the organisation becomes an equal owner, decision making will be transformed and creativity unleashed. But equal ownership rights do not outweigh the differences in status that are accorded by wider society. Organisations made up of members of different status have only functioned as egalitarian democracies when there has been a benign dictator insisting upon it. Julian Tudor Hart has written of the paradox of this.

them to offer services that meet as many needs as possible by using resources as wisely as they can. A focus on efficiency, by contrast, provides no such motivation.

Regulation

We have not yet mentioned the role of the regulator. After all choice and competition are not the whole of the picture, healthcare organisations must satisfy the regulator about the standard of care and in this way organisations can be sure to take care as seriously as financial targets. But as we have seen in Chapter Two regulators are concerned with second order processes and not first order ones – at their distance they can do little else.

If we want good affordable care then what is needed is concerted local action with everyone playing their part. Everyone has to care about care, and they are more likely to do this than to care about second order processes to appease a regulator. Both are clearly necessary but again a focus on one (the second order) decreases commitment to the other, and thus the tougher the regulator gets the less involved will front line clinicians want to be. They will leave it to regulation experts.

There has been a history over the last dozen years of the Modernization Agency and the NHS Institute, both showing people how to improve the quality of care and its affordability. Their reports have had the potential to be very valuable. What has happened in practice? Local staff have been told by their managers to implement the reports (e.g. The Productive Ward) and to hand over the savings that result. This has inevitably led to mixed feelings for the staff charged with implementing them: enthusiasm to improve care (both by offering better care and by liberating resources to spend on other aspects of care), resentment at being told what to do and how, fear at losing more staff resource in their service instead of being able to use the freed up time to spend with patients, and a desire to sabotage these initiatives.

In a different climate these reports could be very useful. Let's reflect that alongside the complexity of the health care task there is a raft of statutory requirements of all sorts (just as one example think of the European Working Time Directive), and all the other NHS pressures of increasing longevity, increasing costs of drugs and technology, and government imposed targets. If we see them as separate tasks, puzzles, each with one person accountable for them then we end up with the kind of delivery we have now. If we saw them as contributing instead to a complex 'mess'[15] which necessarily and appropriately has a rich set of multifactorial aims, and we made (or rather saw, or expected) *everyone* responsible for contributing towards them, then we would need a different way of

[15] As we have seen before, Russell Ackoff distinguished between puzzles, problems and messes. A puzzle has a right answer. A problem does not but can be approached in a way that is better or worse. A mess is a dynamic system of interacting problems.

managing. We would manage through conversation not diktat; through truly engaging with what people care about; fostering constructive dialogue between clinicians; giving credible, rich information about patient experience and outcomes, and about staff experience. We would take a real interest in the behavioural dynamics and day to day logistics. We would want to know whether when people turn up to work they are looking forward to the day; whether everything they need to do a good job is ready for them when they need it; or whether they are going to waste hours during the day trekking to other wards, or offices to find basic supplies or the right forms because 'theirs' are missing. We would want their views, based on their experiences, about how to improve care and use money wisely so we would find ways for these to be sought and listened to.

Size is relevant here. Current conventional wisdom has it that organisations have to be 'big enough to be financially viable'. That is a way of saying that organisations have to be big enough to afford all the specialist expertise associated with the contracting and regulatory processes. And in a system in which, as the Monitor report described, *'Providers, purchasers and transactions are the heart of the day to day running of the [health care] system'* that is the way you can think. But this is topsy-turvey thinking. If we care about good care and good use of money, we might instead say that organisations have to be small enough to allow meaningful clinical stewardship and management of the kind just described[16], and then we would design our regulatory processes to support this rather than prevent it.

Innovation

One of the reasons given for competitive markets is that it results in increased innovation: innovative new products or the development of new processes. In health care these innovations will, it is said, lead to care that is better or cheaper.

Innovation is an important part of economic growth because people can be persuaded to want novel products much more easily than to replace familiar ones - novelty provokes our interest and desire. In health care, like choice, competition and efficiency, innovation has a positive contribution to make and a negative one : thinking of new ways to tackle old problems can genuinely add value; wanting to do something a new way just because it is new can be wasteful and disruptive, if not dangerous.

Innovation is not in itself either good or bad, its moral worth depends on the use to which it is put. The gas chambers of the concentration camps were an innovative use for that technology, for example. The same is true of a lack of innovation, it may or may not be a good thing and we must be careful to maintain current systems that work better than innovative alternatives. Inventive clinicians will pursue technical novelty and so will market

[16] And, more generally, that decisions about organisation or service size should be based on clinical factors

driven suppliers such as drug companies and while this will be important and valuable we also need excellence in areas that aren't novel and don't require novelty so much as attention to detail and effective application of what we already know. Attentive care on Care of the Elderly wards, for example.

And let us remember that lots of innovation does not improve the quality of our lives one iota. Oh we imagine that it will, when our desire for it has been aroused by media themselves competing for snippets of information to titillate us in their infotainment role. Our homes (attics and recycling bins) can be full of goods we once hankered after but which did not affect the quality of our lives, just provided a passing distraction. In health care we can all too easily be persuaded of new illnesses (such as social shyness) or the virtues of a novel pharmaceutical solution rather than a life style one (diet and exercise).

In other words there are occasions when innovation is valuable and those where it is not. In areas like health care (with its asymmetry of knowledge and understanding) we need a buffer between the consumer and self interested competitive players in a market to help us distinguish between them. Who could that be? This is another important role for professionals – as long as the professionals are themselves encouraged to behave as professionals and not as market traders.

One of the arguments for innovation is that novel ideas use resources in better ways, but sometimes novel ideas free up resources that were used in wasteful ways only because they were available. It is believed, for example, that technological developments were slower to take place in Rome during the Roman Empire than in other centres because of the number of slaves. With this ready supply of labour there was no incentive for labour saving innovations. Another example is that of recent innovations in heart bypass surgery. Quadruple bypasses can now, in some cases, be performed 'off pump', keeping the heart going and beating throughout the surgery. Apparently some South American countries have always used a version of off pump procedures since they have never had the resources to do it any other way.

This suggests that ideas don't form or aren't supported when there is a complacent, dominant alternate incumbent. It also suggests that novel ideas respond to the amount of resource available: if there is a lot then the innovations will cost a lot and if there is a little they will cost little – whether in the public or private sector, whether there is competition or not.

So, once again, it is not innovation per se that we are seeking, it is the flexible and imaginative thinking that a genuine concern for a compassionate use of resources will foster.

Those considering a sustainable model for prosperity, one that is not based on economic growth (since that is inherently unsustainable) talk of 'alternative hedonism', that instead of

finding enjoyment in acquiring new 'stuff' or new travel people are (and will have to) find it in other ways – meaningful experiences, purpose: perhaps bringing new meaning to *old* belongings or ideas. In other words using our quest for and talent at novelty in other aspects of our lives, and indeed in the way that we see our lives.

How is this relevant to health care? Perhaps it will mean that the era when patients resented time spent on health care because they wanted to get back out into the market place, earning enough to be obedient consumers, buying more stuff for themselves and their families may, in retrospect, be seen as a blip. Tim Jackson, professor of economics and author of Prosperity Without Growth describes this phenomenon as 'spending money we don't have on things we don't need to impress people we don't care about'.

But perhaps it indicates something else too. That we might change the focus of our search for novelty and put more energy into things like the quality of attention given to patients or the quality of relationship between different clinical professionals. Perhaps we will all remember the importance of the day to day conversations with others that make up much of the richness of our lives and start demanding bespoke interactions rather than automated ones. Perhaps we will find the buzz that we currently associate with novelty *goods*, in an increased sense of meaning arising from using our creativity to enhance our own abilities. Perhaps the novelty is a new us!!

What we need is people thinking creatively about all aspects of care, bringing innovation to ensuring a meaningful day for long term care of people with dementia, for example, just as much as to new devices and drugs.

Ends and means

We can see, then, that choice, competition, efficiency and innovation are all too often talked of as ends, when they are not ends at all but means. If we were to specify the ends towards which they are the means then we could have a properly informed debate about alternative means of achieving those ends. Instead we hear of the importance of choice, competition, efficiency and innovation when what is meant by those words is very different from what might reasonably be understood by those hearing them.

And then we hear the argument that because it is the market that delivers choice, competition, efficiency and innovation we should support a form of quasi market that delivers none of them, not really. If not actively deceitful this argument is lazy, illogical and dangerous.

Language and the NHS

One conclusion we might draw from this chapter is that the language used by governments about public services is interestingly paradoxical.[17] The term freedom is often deployed when those given the freedom feel anything but free.[18] The title Our Health, Our Care, Our Say is the harbinger of 'us' being told what it is that we are to be denied.[19]

Words like choice which seem to offer a benefit to patients instead make life (at least temporarily) easier for commissioning managers and offer no comfort to patients. Competition, that should make choice meaningful, instead takes on an unhealthy tinge when it leads to anxiety as patients feel they are having to compete with others for care. Innovation seems to benefit multinational companies more than anyone else.

When language is so slippery we need to look at outcomes rather than declared intent.

If money is to follow patients, and the market is to ensure that resources go to where they are best used, then let's have a look at just where the money does go. When it leaves the treasury where does it go? And where does it go from there, and from there, where does it end up? How much of it gets as far as front line care? Let's look too at where it is not going. How many people who might once have been on secure NHS salaries above a living wage, and earning decent NHS pensions are now on wages only just above the minimum wage and with no pension rights, needing tax credits to stay out of poverty?

Is money following patients? Are resources going to where they are best used? Let's stop just saying they are, find out and then try to find ways in which they could be.

If the tariff is supposed to ensure that hospital trusts up their game because efficient providers are rewarded and inefficient ones are penalised let us look to see if that is what is happening.[20] If the PFI scheme was introduced because the private sector is more able to deliver projects on time and within budget then let us look at whether the sums paid for these are, overall, greater or lesser than similar builds: either previously in the public sector,

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[17] A point made at the Think About Health Conference September 2010 by David Fuller, Emeritus Professor of English, University of Durham

[18] Universities are now 'free' for instance to raise tuition fees to whatever level they like up to £9000 a year. Their funding has been cut so severely that they have no choice but to raise them.

[19] Think About Health Conference: Femi Oyebode, Professor of Psychiatry at the University of Birmingham pointed out the difference: when Marks and Spencer talk of 'your M and S' they mean to offer us good quality and service. When the government talk of 'our NHS' they mean to tell us what we cannot have.

[20] What do we find? That because the tariff bears no relation to real costs the money being 'saved', as care is moved out into primary care, is fictional and instead of efficiency we have duplication. If we encouraged instead an understanding of real costs and how they behave we could find ways of allocating overheads so that care could become flexible and responsive instead of rigid and 'demand managed'.

or elsewhere in the private. When we do so we may find that some of the contracts negotiated between NHS managers and their private sector counterparts ensure that the NHS not only pays handsomely for lots of aspects that became visible only once contracts had been signed, but bears all of the risk associated with the project.[21]

When we make policy let us not rely on language based assertions, but on a deep understanding of what is actually happening. We have had a recent history of monitoring aspects of the system (such as choice and competition) as though they are ends in themselves when they are not ends but means towards an end. It is perhaps important to remind ourselves from time to time of what is the end: the declared purpose of the NHS, and to remember that Nye Bevan described as ensuring *tranquillity.* Tranquillity that comes from knowing that when care is needed it will be provided, free of charge, for all.

So tranquillity is what we need to measure all these 'means' against.

But we have got out of the habit of considering ends, and perhaps the most frequent confusion of ends with means is that of economic growth. According to the government, the media, economists galore, and business leaders our aim as a country is to restore economic growth.[22] But economic growth is not the end and should never be represented as such. At most it is one of a number of possible means towards what is surely the real end: a flourishing society in which there are dignified relations between the individuals and groups that together make it up, and in which individuals are making progress towards their potential.

If we keep that in mind then we would never suggest that to increase economic growth we take action that causes relations in society to become more hostile or individuals to have their means of achieving their potential further reduced. As we consider how to make the most of a health budget we may find it helpful and ethical to keep these ends in mind also.[23]

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[21] Interestingly this scandal is now blamed on the lack of competence of NHS managers at negotiating contracts with the private sector, not on any avariciousness and behavioural duplicity on the part of private sector companies involved. Traditionally there has been social stigma and significant emotional reaction to the discovery of self centred acts to the detriment of others, and these reactions evolved because they work very effectively as sanctions. These were much more effective and a lot cheaper than layers and layers of oversight or the involvement of large teams of lawyers. The loss of this social stigma and the assumption that everyone is operating only in their own self interest is both corrupting and expensive.

[22] Thus can a spokesman for the rail operators make a case on the Today programme for removing rail cards from young people and the elderly since the focus of those companies should be on enabling economic growth.

[23] For example when actions are suggested that foster resentment towards people who are the victims of a system that is not of their making, actions such as refusal of care to those who are overweight or who smoke - casualties of the ongoing and one sided battle between the food and tobacco industries and consumers