Chapter Two: The making of a vicious circle – factors that affect the nature of care

When we look beyond the mainstream managerial and economic literature to the fields of anthropology, sociology, psychology, history, moral and political philosophy and more, we find vivid descriptions of factors that strongly influence the behaviours and reasoning of all those of us involved in health care. Our responses to these factors are reasonable, not foolish, but cumulatively, as all of us respond to them in a myriad of actions every day, they render the overall system less and less healthy and our experiences of it less and less satisfactory. This chapter introduces those factors and describes their impact on the nature of health care.

Factor One: The Digital Revolution

Although the term 'digital revolution' is in common use, not many of us pause to consider quite how revolutionary our ability to collect, store and mine data has been[1]. It has radically changed our ways of working, of socialising, of spending our leisure time, of holding people to account, of assessing performance, of evaluating evidence about what works, and much more, and we have found those changes beneficial. However it has also had consequences that we may see as not so positive.

Let us look, for example, in more detail at the way in which the digital revolution has opened up to external scrutiny many aspects of professional decision-making.

The use of the computer to record key points from client/clinician conversations and the treatments prescribed therein has led to an ability to compare and monitor the performance of individual clinicians, of teams, and of organisations as a whole. Performance, that is, against particular observable and measurable criteria; for example, whether blood pressure has been checked, or statins prescribed.

---

[1] 'technical code and the manipulation of code, now *constitutes the ground of being of all major cultural systems* including health care systems' Hodgkin P 2007 [paper for the Learning Set]

Similarly, when decisions are made about operational issues or about organisational strategy, discussions are recorded and minutes are kept. Looking these up to trace the pathway of the decision and the factors taken into account would, not long ago, have required tenacity, time, physical access to records, and some understanding of the issues involved. Now these records are available almost instantly to almost anyone who asks.

Our ability to ascertain relative performance in this way, or to trace the path of a decision making process, has led to ever increasing calls for the setting of performance objectives, for targets, for transparency and for information about performance, so that this can inform choice, and also inform decisions about litigation. These calls have resulted in many countries in Freedom of Information Legislation.

All of this sounds positive, or at worst neutral in effect. It assumes that observing an individual, or team or organisation simply gives us information about what they are doing and how. But, as anthropologists and others have noted, the very act of observation changes the process we are observing, and the nature of the data collected digitally changes it quite profoundly.

In short, it has led to the development of what has been described by anthropologists as an Audit Culture. There are many positive results of this: unacceptable practice is identified and addressed, there has been a standardisation of care in which unacceptable variation in outcomes is much reduced and good practice is much more quickly shared. However not all kinds of information are amenable to being collected or codified and the digital revolution has, to date, succeeded in privileging only the data that can. The audit culture that it has spawned thus measures only some of the things we may deem important, and it is worth looking at some of the less beneficial features of this culture

Factor Two: A Culture of Audit

Audit has been described as '*a relationship of power, between scrutinizer and observed*'[2] and this is certainly the way that it is experienced by many in health care. We describe some of the feelings of HCPs on page 45 in chapter Three but the impact is felt much wider than this, so let us consider some of its observable effects:

- *Reduction in creativity*: When performance is measured against objectives, these objectives are required to be specified in advance. While this is often a valuable discipline there are many settings where the precise nature of the endeavour will not be known in advance, and there will be an *element* of emergent creativity in very many more. Thus even where these objectives are set by the people closest to the activity this

[2] Strathern M [2000] Audit Cultures Ch 2

very act of specifying them prevents any creativity or innovation being included when performance is monitored and published. Creativity and innovation are thus given lower priority than performing in accordance with the predefined agreements.

- *We record only the activities than can be codified*: Only activities that *can* be measured *are* measured – so this privileges the use of explicit knowledge over tacit knowledge, and activity at the expense of thinking. It is these measurable 'facts' and activities that are then the basis of 'performance' as made public.[3] In the area of professional decision making, judgement and 'practical wisdom' are an essential feature and the wisdom drawn upon to inform an act is as important as the act itself but is not (and cannot be) captured. Thus 'hyperactivity and discourse are privileged over wisdom and silence'.[4]

- *We don't measure what is happening, only how we are managing what is happening*[5]: As a result of the above points there are difficulties in capturing the nature of 'first order activities' (in health care these first order activities are the interactions between professionals and patients) and thus it is not these that are monitored but second order processes. These second order processes are supposed to ensure delivery of the essential, first order, activity and they include a range of governance activities and performance targets. However the link between these second order activities and the full richness of first order activities is not evident. In other words the underpinning assumption that second order activities lead to first order ones, is not tested or sound.
- *Litigation increases and the lowest risk option is privileged*: As greater information becomes available (although not full information as we have seen, only that which is codified and stored) and as the understanding of the processes of professional decision-making and action become distorted (as consequences of the points made above), so litigation increases. This, in turn, changes decision priorities, so that the lowest risk option is often given automatic priority, even where there are sound arguments for others. After all, if it were not and the worst happened those who took the decision would be pilloried and sued. This in turn leads to a preoccupation with risk, the development of risk registers and requirements to 'manage' risk[6], which all misunderstands the multifaceted *nature* of risk and its different meaning to different people. In fact meaning is something the audit culture ignores.

---

[3] Thus, to put this another way: 'To be audited an organisation must actively transform itself into an auditable commodity. Audits do as much to construct definitions of quality and performance as to monitor them'. Ibid.

[4] Ibid

[5] Or what has happened

[6] This changed attitude to risk is worth emphasizing. Not only does it become the predominant factor in any decision, but risk is now something to be assessed and managed – rather than taken. But as we have noted above, only elements that are codifiable can be recorded. So the elements of risk that are not quantifiable are not given the weighting they deserve. As a result risk has been described as 'the acid bath that corrodes trust'. Beck, B, The Risk Society.

- *Evidence Based Medicine rules the day – and it's epistemological foundations are unchallenged*: The easy availability of information has allowed the development of Evidence Based Medicine, seen as the answer to undue variation in the care offered to patients. As we have seen it has led to many improvements in care, but it has also led to a perceived hierarchy of evidence in which the RCT [Randomised Control Trial] trumps all others. This makes assumptions about the nature of medical knowledge that are left unsaid and untested. It leaves out of sight questions raised about different epistemologies in which, for example, considerations of complexity may be more valuable. It has become, in some cases, a strait jacket rather than an aid. This is explored in more detail in chapter four.
- *Financial aspects become the key factor in clinical decision making*: Information about costs and activity can be linked much more easily than in the past, so the contribution that different parts of an organisation make to its overall 'performance' (i.e. financial performance) can be more readily seen. This then becomes the sole (or at least a major) criterion of organisational support for an activity. While financial data is of course important, and we fully accept a need for financial responsibility that has often eluded the NHS, it is more valuable informing decisions rather than dominating them, especially decisions that have many impacts, not all of which can be anticipated. Please see box 2.1. for an illustration of what we are concerned about.
- *Policy makers set targets: local leaders game the system*: It becomes tempting for policy makers to respond to public dissatisfaction with a service by setting targets for particular aspects of it. These targets relate to easily measurable aspects which do not encompass the whole. The ways in which they can be met can be divided into those with integrity and those without - the latter being easier and quicker than the former. In other words targets can be met as a result of improvements to the system, getting everyone involved to reflect on how things could be done differently and better. Or they can be met by focusing solely on the target at the expense of system.

  So as performance is measured only against these targets and not against the service as a whole it is almost inevitable organisational leaders will 'game' the system and find ways of meeting the targets that do not improve the service.

- *Uncomfortable political decisions are moved sideways:* Accompanying the audit culture, and influenced by the confidence it inspires in counting and calculation, is the phenomenon that decisions that are essentially political have been 'taken out of the political arena and recast in the neutral language of science.' This is discussed in more detail later.

Taken together there is a danger that these often unacknowledged downsides of the audit culture are leading to a change in the nature of care. A change in which patients are no longer cared *about* (I care about what happens to you and about how the quality of our interaction can help you and I will make sure you get the best treatment for you, within the

resources available) but cared *for* (you have condition X for which the best, evidence based, most cost effective treatment is Y. I will make sure you get Y).

We can see this by considering the impact of the audit culture on the health care practitioner dealing with a patient, where it results in:

- An agenda for the care they offer that is neither theirs nor the patient's but is imposed in response to governmental or organisational targets
- Pressure to deliver only care that is evidence based (i.e. that for which the RCT evidence is available) and to ignore other kinds of evidence (even the patient's own experience and worries).
- The knowledge that taking a risk (even a well considered one) may lead to litigation and that if it does organisational support may not be forthcoming.
- Pressure from government, organisational managers and some patients to focus on particular care processes rather than on the patient.
- An uncomfortable clash between two views of professional identity: the autonomous practitioner making a valuable contribution to society through interpretive application of their expertise versus a 'depersonalized unit of economic resource whose productivity and performance must be constantly measured and enhanced'.[7]
- What is more, even when HCPs support particular policy intentions when they are declared by policy makers they do not recognise those intentions in the onerous lists of 'must do's that arrive on their desks months later, having passed through many layers of well intentioned policy implementers each adding a level of detail that enables performance to be audited and reported upon.

Now before we are dismissed as Luddites or romantics, we need to make clear that we all acknowledge that it is important to use data and that there are very many positive aspects of an audit orientation. **We cannot and absolutely do not wish to turn the clock back.** However we believe we should take seriously the way professionals describe the negative aspects of the audit culture and the disempowering impact it has on them.

When features of the audit culture are advanced by policy makers and managers, and health care professionals feel the approach is one sided – necessary but not sufficient – they find that when they seek to have a debate about the importance of other factors (not so amenable to being counted) they are misunderstood, judged to be 'off the pace', left out of decision making, disenfranchised.

As a result they stop engaging in constructive dialogue and in so doing one of the foundation stones of professionalism is threatened: the earned right to professional

---

[7] Strathern M Ed [2000] Audit Cultures Ch 2 The quote continues 'Thus audit technologies transform professional, collegial and personal identities'.

Box 2.1

Participants of a workshop about this work were invited to bring with them examples of good and bad care that they themselves had witnessed. This is one of those brought.

'I was a ward sister on a rehab ward in a district general hospital.

A woman age 50 was admitted who had recently had a heart attack, but she was admitted with weakness in her legs which made it difficult for her to walk. The week she had been admitted she had hoped to return to live in New Zealand and had given up her flat and been staying with friends. It proved very difficult to diagnose what was causing this weakness but gradually she deteriorated and lost the use of her legs and gradually became weaker and weaker until she was no longer able to lift her head.

During these weeks and months, we as a team cared for all her physical needs, and also provided emotional support during a very frightening time. Eventually she was diagnosed with an extremely rare syndrome and had various forms of treatment including radiotherapy and a stem cell transplant. Some of these treatments took place in other hospitals but she always returned to us for rehab.

After being successfully treated she required months of intensive rehabilitation until eventually she was able to fly home to New Zealand.

I look back on the care we gave her as being of a very high standard. However soon after, the rehab ward was closed and one of the reasons given for this was that it was too expensive, patients stayed too long and this patient was cited as an example of what was wrong with the ward[8].

I have heard recently that she is now able take steps in the gym and is living independently and that gives me immense satisfaction.

[8] Just to be clear about this. We are not for a moment saying that financial considerations are not important, we believe deeply that they are. At a societal level however the costs of these rare cases can be afforded in a way they cannot at a local level, that is why we have a national and not only a local health service. We have to find a way of making the money flow, the alternative of not offering the care is simply inhumane. The ability to count costs more easily than benefits distorts, in an *audit culture*, our decision making priorities towards the inhumane.

autonomy[9]. Where there is no opportunity for dialogue and debate, because advocates of audit misjudge those who have reservations, then the audit culture becomes the accepted norm and health care professionals find themselves hostile to it without being able to articulate what it is they find so wrong about this. At the same time they are seen by managers and policy makers to be resisting change and a vicious circle ensues.

Factor Three: the Triumph of Reason and Managerialism

While the audit culture was enabled and fuelled by the digital revolution its origins are much older. Arguably it started with double entry book keeping in the fifteenth century but it is unquestionably associated with the flowering of management over the last hundred years, as a distinct set of practices and approaches that can be applied in any field at any time. Taught in the business schools that developed within US universities in the early twentieth century it has become one of the most popular university subject areas.

John Ralston Saul, a Canadian political philosopher who has himself experience of the management and business worlds argues in his book Voltaire's Bastards that this management method is one example of *reason* separating itself from, and out distancing, the other 'more or less recognised human characteristics of spirit, appetite, faith and emotion, and also intuition, will and experience'.

When Voltaire advocated the use of reason as a basis for society, Saul argues, it was to oppose the arbitrary use of power by an immoveable elite – the aristocracy. Were Voltaire to return today he would be horrified to see how 'dictatorship of the absolute monarchs has been replaced by that of absolute reason'. 'It has reached an imbalance so extreme that the mythological importance of reason obscures all else and has driven the other elements into the marginal frontiers of doubtful respectability'.

In the discussion that follows we look at the development of a particular management method and how it exemplifies this wider insistence on the value of reason and logic over other ways of knowing. Please note that as we do so we are not doubting that individual managers can add value, nor indeed that there are many highly effective and even inspiring managers. We are not anti managers, merely reflecting on a particular (and increasingly dominant) style of management. One which Henry Mintzberg has termed MANAGERIALISM (capital letters are his).

---

[9] That right is earned by being willing and able to talk about the roles of professionals in a changing society, and by remaining in touch with what patients value in a relationship with a health care professional. We will discuss this further in Chapter Four

At the heart of teaching at the most prestigious business schools is the case study method in which information about a business or industry is taken away from its rich, complex reality and turned into a 10-20 page description. In this move from reality to story all sorts of things happen. Humans described in them become a set of rational interests, nothing like the people we meet in real life who have emotions and beliefs and experiences all of which influence (even govern) our choices and behaviours as much as does our rational self interest. For better or worse but certainly for richer, we are all much more vivid, complex and interesting than are the ciphers represented in these case studies. The same is true of the settings depicted. As a result the situation is turned from a 'mess' into a 'puzzle',[10] something that can be solved using the formidable intellect of the students and the logical decision methods of their teachers.

So management is taught and has developed in ways that allow logic and reason to trump all other ways of knowing what is really going on in a situation[11].

The rise of this management method has accompanied the increasing size of organisations, and perhaps this is inevitable. Once you cannot know the people in your organisation, and the messiness of the situations they are dealing with, then you have to steer by a set of numbers or other abstractions (such as replacing people with a set of rational interests) and not by what is really happening.

And once you have replaced the need to know reality with a set of numbers and 'facts' that you can collect, then the size of organisations that can be managed has no limit.

Saul argues that our belief in reason and management is just that, a belief. '*Today we are in the midst of a theology of pure power. The new priest is the technocrat, the man who understands the organisation, makes use of the technology and controls access to the information –which is a compendium of 'facts*''. What is more, because the belief is so firmly held it is invisible and hence impossible to argue against: *'To argue against reason means arguing as an idiot or an entertainer who seeks only to amuse. The structures of argument have been co-opted so completely by those who work the system that when an individual*

---

[10] Russell Ackoff the systems theorist is credited with the distinction between puzzles (a conundrum to which there is an answer, it may take a while to find it or a number of experts to ask, but there is one), a problem (a conundrum to which there is no right answer merely better or worse ways of dealing with it) and a mess (a dynamic interactive system of problems). A similar distinction is explored more fully in Chapter Four.

[11] Unfortunately management can be sadly ill informed by other bodies of knowledge and with little examination of its underlying epistemology (how it is thinking and the assumptions that this rests on). Much of its research is incestuous, for example asking current managers for their views about good management, or measuring yardsticks defined as critical by managers rather than anyone else involved, or asking what they think they do rather than observing what they *do* do. And it then often draws on literature searches that encompass only management, leadership and economic literature.

reaches for words and phrases which he senses will express his case he finds they are already in active use in the service of power'.

Had the application of management methods yielded consistently positive results we might then have to accept the virtue of privileging reason over experience, however they have not. If we look at what happens when reason is detached from experience, values, desires, beliefs and meaning we come across examples such as the following:

- Business Process Reengineering (a process of the 1990s in which whole organisations were completely redesigned around an idea that had no evidence to support it, only logic, and failed utterly)
- The dominance of Evidence Based Medicine in domains where it is inappropriate. While evidence informed decisions are vital, decisions dictated by the kind of evidence privileged in EBM are appropriate in only certain contexts. (Before you reject our argument here please see Chapter Four for a further exploration of this)
- QALYs advocated as the basis for resource allocation decisions. (Again, see later in this chapter)
- The turning of every rich policy idea into a set of well intentioned, rigid descriptions and prescriptive guidelines. (Chapter Three)
- Rich terms and ideas being operationalised in impoverished ways (e.g. 'patient safety' is translated merely into targets for cleanliness)
- The dominance of explanation over empathy. HCPs and HCOs[12] no longer apologising or empathising with the distress expressed by people about their care – instead explaining why it is how it is [13]

And in spite of manifest signs of failure we have no means of questioning the underlying method. When there is 'expression of any unstructured doubt[14]… it is 'automatically categorised as naïve or idealistic, or bad for the economy or for jobs'.

We have lost sight of the fact that this is only one way of looking at and understanding organisations. We fail to observe that when we leave out feelings, deeply held values, the meaning people place on and derive from aspects of their work then our logic can so easily lead us to many, many 'reasonable' heartless decisions.

---

[12] Healthcare organisations

[13] In a similar way that children and adolescents protest their good intentions when their actions cause distress.

[14] unstructured doubt is doubt rooted in something other than pure logic e.g. experience, intuition, tacit knowledge and the deep understanding this embodies but which cannot be expressed in ways the person using only reason can understand - or even recognise

And yet in spite of this there always are people who do resist these reasonable decisions. And many more of us than actively fight against the explanations of those who espouse only logic, do experience an increasing sense of overall distrust. Distrust of spin, and of political and managerial success stories – especially when these are accompanied by a what we perceive to be a failure of common sense and ordinary humanity. As Saul describes, the 'phenomenon of technocrats… versus practical humanists plays itself out in every sector of our society. It is endlessly repeated with the same imbalance and the same results. The more these conflicts are examined the clearer it becomes that certain of our most important instincts- the democratic, the practical the imaginative – are profound enemies of the dominant rational approach' [15]

So we suggest that the managers who genuinely add value to the teams, services or organisations they manage are those practical humanists rather than the technocrats. People who use data and logic but also draw upon experience, tacit knowledge and intuition. People who are in touch with other aspects of themselves and others than their brains.

But of course if logic is the answer to every problem then only people who can reliably draw on logic are valued and recruited. So these practical humanists are under-represented in senior positions. Indeed we now have a requirement in many job descriptions for 'emotional intelligence', people who will be able to draw on reason and not be diverted by emotional responses. In this way we are turning our bureaucracies inwards so that we engage in 'governance of the soul', and are appointing, to run our organisations (or even join them), only people who can achieve this.

How has this happened? We are now in the hands of a self perpetuating elite. In the West we now have elites in every country who have been trained in the same way – whether this is Harvard, the ENAs in France, or the elite schools of any country. And the elite believes that it is acting in the best interests of all.[16] A sociologist might describe the phenomenon as 'professional capture'.

As an example of this capture, it is noticeable that in the wider economy as well as in health care, and right across the West, there has been a massive increase in salaries for top managers. NHS top salaries exemplify this. As jobs became bigger and more complex and more important (and therefore needed the 'best' people) so salaries leapt.

---

[15] Saul. Ibid.

[16] Ibid 'like all functioning elites they seek to perpetuate themselves for the general good. As always this involves the creation of an education system'.

This raises the question: are some jobs too big to be done and too important to risk giving to one person?[17] But of course part of the professional capture, the rationale for an elite, is the engendered belief in some people having been sprinkled with pixie dust so they are no longer mortals but 'leaders'.

Before we are deemed to be unremittingly hostile to managers and management may we point out that we are not. Many people complain about the number of managers in the NHS, Saul would probably argue that it is not only the *number* that is the issue but the *method*.

What we are arguing for is management that certainly uses reason and analysis but also values and uses experience, feelings, a belief in others, and an ability to articulate a direction of travel for the organisation that encompasses the enthusiasm and concerns of others. This is so far from the kind of management that is currently valued as to sound old fashioned and out of date. And yet we know that many managers feel they are uncomfortable about the persona they have to wear when at work, the bullying and steam rolling they are required to undertake. And we should be even more worried about those who are not uncomfortable with this.

Factor Four: a Change in the Nature of Politics

Just as the digital revolution has fanned the flames of the audit culture, so it has accompanied and fuelled a change in the nature of politics.

Historically democracy has been described as a process of 'becoming', in which people become more able (in terms of competence and character) to reconcile different interests within society. Indeed the election of a governing body was once the outcome of democracy and not its purpose. So it inevitably involved dispute and the conciliation of conflict and a certain 'politicalness'. Not any more. Sheldon Wolin observes that 'Politics has become the rational administration of liberalism, where liberalism is defined as freedom, private industry and un-coerced relations between individuals' and he suggests that because it has been replaced by management procedures and market mechanisms we need to *rediscover* 'politicalness', i.e. 'the capacity for developing into beings who know and value what it means to participate in and be responsible for the care and improvement of our common and collective life'.

Alasdair McIntyre also notes that 'The modern state is run by oligarchies disguised as liberal democracies in which what passes for debate is the antithesis of serious intellectual enquiry.[18] Philip Blond, reflecting on how politicalness can be developed, suggests that

[17] Especially when in reality the same individuals moved around the same strata of the system at ever higher salaries

[18] After Virtue, a study in moral theory

serious enquiry has to emerge from *local* reflection and *local* political life, constructing in local communities a sense of the common good and translating that into things we can see and feel: services and buildings.

We will look later at the importance of developing 'politicalness' within health care but first let us look at what changes there have been in the nature of politics and see how these have been fuelled by the digital revolution. How it has, for example, influenced profoundly the behaviours of the politicians and the characteristics of the arguments that win elections.

Appealing to voters

As a result of mass communications politicians are elected on the basis of televisually appealing sound bites and on being able to justify their actions via the 'infotainment' industry.

Being able to defend decisions, in an era when details of the conversations that led to them can now be accessed through FoI Act procedures (and sometimes by phone video clips on YouTube) now requires that politicians say nothing of any consequence or that they hedge comments around with so many caveats as to be worthless. Thus, as Saul puts it, there is a belief that 'public policy must emerge mysteriously, fully formed.' But, as he points out, 'The proper debating of policy is not smooth, Words are not air. Talk is not a waste of time. Arguing is useful. And speed is irrelevant unless there is a war on.'

Thus the kind of dialogue that could result in good policy is increasingly difficult. Policy is now about intentions, and about delivery, enforced through special delivery units set up to monitor performance against arbitrarily set targets. This performance can then be trumpeted in the media, whether or not it accords with the wishes or experiences of people on the ground.[19]

Furthermore, to increase their popularity (or decrease the risk of unpopularity) politicians increasingly leave decisions where the just or wise outcome is likely to be unpopular, to 'neutral' bodies such as NICE or the Bank of England. Or of course to the market. However, this lack of real debate, far from reassuring the public leads to a growing distrust between politicians and public.

---

[19] As a result, as Saul argues, 'throughout the West we are led by elected and non-elected elites who do not believe in the public. They cooperate with the established systems of democracy but they do not believe in the value of the public's confidence. Nor do they believe in the existence of a public moral code. This means that in dealing with the public they find it easier to appeal to the lowest common denominator in each of us. That this succeeds reinforces their contempt for a public apparently capable of nothing better. They do not take into account that the public, like any of its members, is in fact capable of the highest and the lowest. '

What does this mean in healthcare? It means the introduction and advocacy of a quasi market. Resolutely dissimilar from a genuine market place in which consumers shape services by virtue of their many individual purchasing decisions from a range of competing suppliers, the quasi market seeks to feature many aspects of the genuine article (such as choice, competition, efficiency, innovation).

What it also means however is that decisions reconciling different interests (between different groups of patients for scarce resources for example) are no longer taken by the people whose profession this is (politicians) but are left to 'the market': the commissioners of care contracting with care providers. But the commissioners are not the consumers, so someone has to turn these impersonal commissioning decisions into lived reality for patients – and that role falls to front line staff.

This has led to many professionals trying to fulfil more than one role, and roles where the aims and decisions are different, within the same encounter with a patient. The anxiety induced in both professional and patient as a result has led to an expensive and unsatisfactory vicious circle in which (in arbitrary, not causal, order):

- Professionals feel alienated from the patient in front of them and from patients in general
- Patients worry that the professional is operating as an agent of the state and not considering their welfare, and then express their own needs more forcefully as a result
- Patients feel alienated from professionals, for example feeling that they should not take up their precious appointments or time, and that they cannot get to see professionals when they want or need to.

In this situation both patients and professionals feel their relationship is with the State (and a rather malign and/or incompetent State) and lose a sense of having relations with a collective – society.

Politics as Administration of the Market

Now that politics has become the rational administration of the market, so the emphasis, in public sector services as well as private, is on choice and competition. (Interestingly the market itself is not required to compete and be chosen as a model.)

But where does this belief in the efficacy of markets come from? From experience? From history? From convincing evidence? Actually no. Saul, among others[20], is persuasive when

[20] Saul is far from alone, the reason I quote from him extensively here is that his language is powerful and relates especially well to the issues we are exploring

he argues that globalization (the wider term for the market) is the result of 30 years of applying the thinking from a particular school of economics, and that it was (and is) presented as 'inevitable' when in fact it was an experiment.

How this has happened, Saul argues as follows.

The promise of globalisation was that it would increase wealth and well being because of multiple players competing to exploit the last hundred years of technical and theoretical breakthroughs – by letting commerce lead civilisation and allowing commerce to lead and regulate itself. Interestingly 'no serious thinker on any continent at any time has ever suggested this before'. In other words civilisation has been reformed from the perspective of economic leadership – 'for the first time in history the economic perspective is equated ('sotto voce') with people behaving in their own self interest'. He notes that throughout history societies have tried to find ways of balancing self interest with a concern for others and for society as a whole, and that this is the first time concern for society and others is to be enacted *through* self interest.

So what have been the results of Globalisation? It has indeed delivered very great increases in trade, and also in technology, especially information and communication technologies.

It has also led, according to Saul, to a reduction in public and social capacities, the vaporisation of money through imaginary market activities, lots of binding international agreements about the market and not any about work conditions, taxation, child labour, health, … etc, the return of oligopolies and monopolies, a significant number of people in developing countries becoming poorer while statistics show them becoming richer (because of the things statistics measure), huge reductions in the amount of tax paid by corporations, a shift of the tax burden in almost every country from the wealthy to those on middle and low incomes (often through stealth taxes such as lotteries), increasing inequality of incomes within countries to the level they were at in the 1880s, steady increases in unemployment with the largest being in long term unemployed, major migrations around the world as richer countries import labour to take up menial roles their populations no longer want to take on, companies constantly moving manufacturing facilities to cheaper sources of labour building in 'boom and bust' cycles every time they enter a new country for this purpose.

How can this be? When there is so much more trade? So many people competing in their own interests to exploit the technology that will allow us to meet needs? Partly because much of the increase in trade is actually movements within multinational companies between countries to avoid tax. But what else? Could it be that the underlying assumptions are flawed? Throughout history, markets have been seen as essential but not of primary importance for the citizen or civilisation, and there has been constant argument about the balance of public and private enterprise. In other words that there is nothing inherently 'inevitable' about globalisation, inevitability has been a convenient tenet of an ideological argument, convenient in that, in the face of inevitability we have no choice but to toughen

up. Saul quotes Gerard Baker about the 'sadomonetarism of the ruling school of economists'. He notes that 'in a world of ideologies moderates are always wimps, wets, soft' and that when things get worse rather than better we are always exhorted to 'give it more time, these are big changes'.

No, this was a choice, a set of assumptions made from the '70s onwards, when as Saul observes we had the first generation of the technocratic elite coming to power, whose concept of efficiency took them away from their properly big concerns towards the things for which they were 'accountable' –held to account. For example bankers steered only by inflation statistics and not poverty figures or even the way money flows in an economy. These accountable 'technocrats' spanned industry, public sector and politics, and it was only a short step from there to politicians using globalisation as a reason why they could not make national policy decisions over anything that mattered, saying that their hands were tied. So globalisation is not an inevitable force of nature, it is the result of a MANAGERIALIST focus on efficiency and accountability, themselves resting on the false assumption that everything can be measured and counted.

One result of this has been that if politicians are seen as not able to influence anything of importance people don't see any difference in who they vote for, hence the decrease in voting figures across the West and a further move from politics and politicians to managerial administrations.

The market in health care

With politics now the rational administration of the market, globalization 'inevitable' and managerialism (sorry MANAGERIALISM) the method by which organisations can be stewarded into competitive shape, it was inevitable that market principles and practices would be introduced to the public sector.

There has been resistance to this introduction of market principles within public services and much of this resistance has been dismissed as self interested or ill informed, or naive. However as has been noted in Strathern [2000] 'For *anthropologists resistance to reforms is not to do with complacency, backwardness, laziness, inefficiency etc. Opposition is encapsulated in a whole symbolic complex through which people can feel their realities traduced*.' [21] To understand why the predominance of market concepts may be seen as negating something many professionals and patients see as vitally important (see their realities being traduced) we need to introduce some concepts from the literature on other kinds of economy.

[21] McDonald. M, Chapter 4, Audit Cultures Ed Strathern M [2000]

It has been assumed by many in the Western world that the market economy is the only kind, but if we look across history and geography we find others. The gift economy is one that has received much consideration.

Non-market economies

In societies that were or are essentially gift economies[22], items surplus to requirements are not traded but given away. Furthermore the gifts move; they are given on to others, and are not treated as exclusively the property of the person to whom they have been given. In a gift economy a person or family acquires status by being able to give away more than others. Reputation is gained by the act of giving, and is lost by acts of meanness and personal enrichment.

There are other differences. In a market economy items have *value* – this value can be compared with the value (often a monetary value) of other items so that a choice can be made between items of different attributes but similar value. Another way of saying this is that people choose between competing offerings of the same price.

In a gift economy some things have *worth*. Worth cannot be compared with a dissimilar attribute; it can only be compared with itself. In a health care context we might put life into this category for example. Trying to put a *value* on this is fraught with problems and will always feel uncomfortable, rightly so.

Similarly in the market economy we care about what it is that people *do*, we call this *work*. In a gift economy for at least part of the time people are engaged in *labour* that requires that they give something of *themselves*, so that the kind of person they are is important as well as what it is they do. Work is clearly easier to track and to measure objectively than is labour.

With the dominance of market principles in public services, leadership has increasingly shifted to those who do not perceive or understand gift economies[23]. This is a new phenomenon. Previously management teams in health care included numbers of historians and philosophers, and others from the liberal arts and humanities, as well as members of the professions themselves. No longer, and as a result the lens through which health care leaders see the service is now that of the economist working within an audit culture. This is a point worth emphasizing: the very way that healthcare leaders conceive of health care has

---

[22] See Hyde L, The Gift.

[23] And when they do notice them they try to fit them into their 2 dimensional framework by reducing rich feelings of gift and belonging and other aspects of non-market economies to the term 'utility'.

changed. The language may stay the same but it means something different[24]. Words which have one meaning in a world that has an understanding of and commitment to human, non-market values take on a different meaning when seen through the cynical self interested lens of the economist.

Little wonder then that when the economic managerialist paradigm was introduced to the NHS in the 1980s, although it seemed valuable because it added a dimension that had previously been missing, there *was* resistance, some clinicians refused to 'play the numbers game' as they 'cared for people and not for statistics'.

As the economic/managerialist paradigm has become dominant, these feelings of frustration on the part of professionals[25] have not gone away. Some have been targeted at private sector ownership within the NHS but arguably it is not the ownership that matters, it is the loss of the gift economy that does. The loss of the element of gift means that the nature of care changes profoundly[26].

Factor Five: The Role of Anxiety

Anxiety is an emotion that is very valuable. It prompts us to take greater care about (or within) the situation that prompted it. And yet it is uncomfortable. So it is an emotion that, as individuals and as groups, we can go to great lengths to avoid. Psychotherapists describe these lengths as social defence systems. In other words we can respond to anxiety in ways that are healthy in that they use this emotion to achieve positive ends, or unhealthy in that the anxiety is reduced in ways that do not address its original cause.

Healthcare necessarily involves dealing with situations that are difficult, emotional or unpleasant. For example, it can involve dealing with death, pain, grief, mess, or decisions about allocating scarce resources. All of these will tend to make health care professionals anxious and they (we) will construct defences against this anxiety.[27] Many of these

---

[24] For example 'personal care' has four distinct meanings:

- Care that meets the preferences of the patient as far as timings and locations of appointments are concerned.
- Care that meets needs diagnosed with accuracy for an individual using and genetic and other data.
- Care that forms part of an ongoing relationship with the patient and perhaps their family.
- Care in which someone gives a hoot about what the experience is and the outcomes are.

[25] as well, admittedly, as those of self interest

[26] The loss of the gift economy has occurred to as great an extent in public sector as private sector organisations. Many dedicated HCPs leave the NHS to work in the private sector because they want to offer better care than they are able to do within the NHS.

[27] For health care professionals, a core anxiety is the *unpredictable* nature of health, disease and illness, and so we often erect defences to try and make it predictable (and in the process to keep it at a safe distance).

defences are subconscious, they are ways in which we 'contain' our anxiety – keep it within bounds we can cope with.

Healthy responses to this professional anxiety involve things like:

- bringing it into awareness,
- reflecting on the source of it,
- seeking support where we need it,
- thinking carefully through the needs and wishes of the other,
- reminding ourselves of our sense of purpose.

If we think clearly about these various concerns and interests (our own and those of the other) then we are able to make a free choice about how to respond. That response may be a decision to embark on a course of 'aware altruism', the taking on of a difficult or distasteful task because of our concern for the other and our preparedness to put their needs ahead of our own preferences. Or it may result in a meaningful dialogue with the other, without knowing what the outcome of the conversation will be and tolerating that uncertainty. Or it may involve seeking support from someone more skilled in a particular procedure.[28]

Unhealthy defences, on the other hand, include blaming others, rushing into action that may not be the most valuable (looking instantly for a suitable protocol for care before really understanding the issues, concerns and expectations of the patient for example), or looking for something that needs doing that can take us away from the source of the anxiety (stock takes and other forms of counting such as looking at the patient's chart or returning to our computer screen where we are likely to find deadlines for reports etc, imposed by other people to which we can feel we must respond and which we can then blame).

Given the adverse impact of unhealthy responses compared with healthy ones it is surprising that we do not teach people to become aware of their anxiety and how to respond to it constructively. Yet we do not, largely because of the impact of the audit culture on educational processes which we will explore again in Chapters Six and Seven.

Anxiety as patients

If we are anxious as health care providers then so too are we as patients. Naturally we are fearful of our own mortality or the onset of an incapacitating illness, and in a market-driven

[28] We are, of course, much more likely to be able to do this if we are merely anxious and not anxious about (or ashamed of) being anxious! This is an important point, if we do not teach our young professionals to value anxiety they worry about being seen as anxious.

society where as consumers we are told we can 'have it all' and where family structures are often broken or dispersed and there is a reducing sense of community, we have fewer societal opportunities for containing our anxiety than we would once have done. So, as patients facing these issues, we often turn to health care professionals for solace, guidance and support: a relationship. If we then find the same market-driven transactional culture within health care that prevails in wider society and feel 'held at arm's length' by the professionals in whom we wish to place our trust our anxiety increases. As it does so, we try to exert more control, asking for greater accountability, transparency etc, not realising how this will increase anxiety all round (including our own).

Furthermore, anxiety combines naturally with the other factors described in this chapter, contributing to the development of the audit culture, the increasing dominance of technocratic management, and the decrease in politicalness. And we can see these as a vicious circle in which they prompt further anxiety and hence more audit, more MANAGERIALISM and less politicalness, and so on.

Politics and anxiety

When we observe the pervasiveness of anxiety we can see it is certainly no stranger to policy makers and politicians. How could it be otherwise. The number of unintended consequences is always great, inevitably, and the impact on the electorate will depends on 'events' as much as intent or competence.

One particular result of this is a phenomenon we have observed earlier, that of recasting political decisions in the neutral language of science. Political decisions involve reconciling different interests, often interests that cannot be reconciled to the satisfaction of all. What a relief it is to be able to shed that responsibility and hand it over to an impartial, objective, scientific body such as NICE.

However, as with all short cuts (where we try to reduce time or anxiety) there is no such thing: the fundamental tension does not go away, it simply reappears in a different form. Here the political decisions are moved into the ways that QALYs are derived and the weightings given within the calculations.

Anxiety and the gate keeper role

The gate keeping role can be a cause of greatly enhanced anxiety, for both professional and patient. Knowing that 'my case' is being compared with someone else's by a HCP who is expected to help balance the books, patients can ask themselves (consciously or sub consciously) "does he or she care about *me*?", 'may I be abandoned by this care giver in whom I'm placing my trust?', 'should I perhaps respond to them with less trust, or abandon them and use the internet or find a complementary therapist as an alternative health care advisor?'. Again a vicious circle is developed- in which a sense of healing and trust is lost.

MANAGERIALISM and anxiety

Another way of conceptualising the difference we explored earlier in this chapter between the manager as technocrat and the manager as practical humanist is to distinguish between the *simple, hard* and the *complicated, easy* of management: the complicated easy requiring only intellect and the simple hard requiring things like courage, integrity, judgement. The target culture of the NHS over the last 10 years has undoubtedly led to the complicated easy squeezing out the simple hard. Or to put it another way: performance management has replaced good management.

What is it that pushes people who are basically good towards the complicated easy from the simple hard? Undoubtedly the attraction of interesting ideas for able minds plays a part. But so do the uncomfortable emotions associated with the simple hard. It is much easier to retreat to writing a strategy document than to listen (really listen) to the concerns being expressed about a situation and then respond in ways that are fresh and humane. It removes a lot of the emotional distress of management and the difficulty of dealing with the distress of others. So MANAGERIALISM too is a response to anxiety.

Using anxiety well

If anxiety is so pervasive then we would do well to develop within our HCPs and our organisational leaders and policy makers the ability to respond healthily towards it, and yet we do not. The processes of education and training for most HCPs concentrate almost entirely on knowledge and skills and on observable, objectively measurable competences. After all these educational processes are themselves subject to the five factors and the audit culture is changing them just as substantially as it is changing health care. So they now tend to focus on what people *do,* not on the kind of people they can *become*. The implications of this are profound and we explore them further in Chapter Seven.

Five winds and a vicious circle

In this chapter we have looked at five factors, five forces which we could usefully compare to five 'winds'. These winds, we suggest, surround us all and influence our actions without our being aware of them. We have chosen the term 'wind' because a wind is part of our immediate environment that is beyond our control - and yet we can find more and less enjoyable and useful ways of coping with it. More than that, our responses could be thought of as breaths that either add to the wind or counter it, so that although individually those breaths have miniscule impact, collectively they are what the wind is made of.

These five winds, our responses to them, and the vicious circles that entwine them together are leading to progressively poorer care, higher costs, and more dissatisfied staff. Our

attempts at reform do not tackle the underlying causes of the poor care, higher costs and demotivated staff, which include our unhealthy responses to the winds, instead they merely provide the next step in a vicious circle that encompasses all of these factors.

If there were limitless resources or reducing health needs this might not matter, but our increasing longevity and changes in family structure, combined with advances in technologies of all kinds mean that we urgently need everyone involved in healthcare to respond thoughtfully and healthily to the five winds. Instead of their current naturally unaware unhealthy responses we need them (us) to think carefully and responsibly about how to offer good care for the greatest number of people. In other words, they (we) must think with care for patients, and the wider public and other people involved in providing care, about what we ourselves can do and about how we can act as agents for the results of our thinking.

This requires a completely different approach and not just another cycle of the vicious circle.

How can we do this? How can we free ourselves from this vicious circle? That is what we start to explore in the following chapters.