Is doctors' self interest undermining the NHS?

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YES Self interest is an integral part of every human's programming. The challenge is not to eradicate what is impossible to remove but how to channel these powerful forces to serve the individual and the public good. Economists regard self interest as the engine of economic development. As epitomised in the writing of the economics Nobel laureate Milton Friedman,¹ the challenge for society is how to use self interest as an engine not only for economic development but as the means to maximise individual freedom in decentralised, competitive markets.

For Friedman and his 18th century predecessor Adam Smith,² the "invisible hand" of self interest and the individual pursuit of improvement in a free market with minimal government regulation would ensure that society's scarce resources were used efficiently and economic growth maximised. This, in theory, makes self interest good.

This simplistic view ignores the realities of most markets, and the healthcare market in particular. Health care internationally is characterised by government sanctioned cartels such as trade unions (like the BMA) and the patent protected drug industry. Drug companies use high prices to fund research and development, which in the past decade has been disappointingly ineffective in bringing novel cost effective products to market. And poor governance of trade unions has meant they have perpetuated the inefficient use of society's resources while remaining successful in achieving the personal and professional goals of those they represent.

Doctors' self interest manifests itself in two ways: enhancing personal income and fiercely protecting clinical autonomy—the right to do what they think is best for the patient in front of them. The first type of self interest has enhanced average UK earnings to over £100 000 for both general practitioners and consultants with little observable improved activity or patient outcomes.

The general practice quality and outcomes framework inflated earnings by 30%,³ but with a limited evidence base and

little baseline data its benefits are uncertain.^{4,5} Furthermore, by moving away from traditional non-financial incentives to payment for results, the NHS may have undermined public service values that emphasise the importance of trusting professionals to behave efficiently and created a system whose transactions costs, in terms of policing, may be high.

The consultant contract was also expensive and its design paid scant attention to inefficient variations in clinical practice, substantiated in policy literature for decades,^{7,8} the continuing long term decline in clinical activity,⁹ and the absence of outcome measurement.¹⁰ The potential in the contract for improving productivity by collaborative management, particularly of the content of job plans and clinical excellence awards, remains largely unconnected to quantitative management of activity and outcomes. This pay increase has inflated NHS expenditure with all too little benefit to patients or taxpayers, while giving more general practitioners incentives to deliver what good practitioners were already providing.

Clinical autonomy

The second area of doctors' self interest is the understandable desire to do the best for their patients. Rationing requires doctors to decline care even when patients would benefit from it and would like to have it. Doctors should not support patients' demands for care of marginal cost effectiveness when that inevitably results in depriving other patients of care from which they would benefit more. Furthermore, they must resist lowering treatment thresholds without evidence of cost effectiveness. A doctor's concern for the individual patient and their self interest can lead to inefficient practice that ignores the opportunity costs of decision making—a decision to give Jones a marginally cost effective treatment deprives Smith of cost effective care. Such inefficiency in the use of society's scarce resources is surely unethical?

Making self interest work

Self interest and responding to financial incentives are an unavoidable and potentially beneficial aspect of human behaviour

if they are channelled into improving the performance of the NHS. Recent reforms have ignored this potential to improve patient care, putting the pay rise cart before the productivity horse. These pay increases, together with workforce management which has led to unaffordable employment increases, are creating deficits and undermining patient care and the financial performance of the NHS.

An essential part of the mitigation of these failures is the linking of reward to performance, in terms of activity and the measurement of patient outcomes. Shifting the focus to whether care improves patients' health will create "signals" for targeting cost effective investment. Without such signals inefficient governments that mispend taxpayers' resources and powerful providers focused on short term gaming will continue to undermine the NHS. Instead of talking merely about money, we need to determine whether its use benefits patients or is merely a form of social security for providers.

Competing interests: AM has been chair of York NHS Hospitals Trust since 1997. He is a member of Department of Health committees on payment by results and information and a specialist adviser of the House of Commons' Select Committee on Health for their workforce inquiry.