From Our Irregular Correspondent

The Origin of Health(care)

One in a series of occasional papers on health and social care topics by Terry & Monica Dennis of Healthcare Alliances. The purpose of the papers is to give a high level view of current issues – making serious points in a casual style.

This paper explains why the Government cannot predict how healthcare will evolve, but can help the NHS to evolve.

Vilfredo Pareto was an Italian sociologist and economist who identified that 80% of the wealth was owned by 20% of the population. This has developed into the 80:20 rule – 20% of beer drinkers consume 80% of the beer that is made; 80% of the useful stuff in meetings comes from 20% of the discussions; and so on.

So what does this mean for health and social care? It means that 20% of patients/users will consume 80% of health and social care resource. Simple so far.

We believe that it is the application of the Pareto Rule that ignites the fierce passions in the ethical and moral debate in the UK centred on "which 20% of patients should it be?"

We will illustrate the issue by considering the two most often quoted extremes of western healthcare systems. The USA has a market model of healthcare delivery based largely on the ability of the user to pay. So 80% of healthcare is consumed by the 20% who can afford to pay the most for it. The UK's centralised system is based primarily on need, not the ability to pay. So, in broad terms, the 20% of people who have the greatest need consume 80% of the resources.

So one thing is clear – there is not equal access to healthcare in either system. In the market system (US style) it is based on the ability to pay; in the centralised system (UK style) it is based on the having (or, more accurately, demonstrating) sufficient need. Both systems have their weaknesses. The market system can lead to the extremes of either over delivery (over treatment) or no delivery (no treatment). The centralised system is slow to innovate and can be unresponsive in individual cases.

All of us can see weaknesses in our own systems, but we think our system is fairer because of our culture and values of fair play; the residents of the USA think their system is fairer because it means that people who have worked hard and are successful can reap the rewards of their labours.

In the UK, despite the perceived problems with the NHS, we are proud of the principles of universal access (but not necessarily treatment) and services being free at the point of delivery.

The problem with our system is that it is predominantly centralised thereby leading a "closed system", which is a system that is energised internally – a product of the recycling of government policy, imposed structure and loss of authority.

By contrast, open systems get their energy from many different sources. A current example is the internet, which is continually developing, adapting, mutating and changing. Open systems generate innovation; closed systems are characterised by entropy – a tendency to move towards a state of chaos.

Closed systems have a time and place, useful as starting blocks but perhaps the time of the NHS as a closed system is coming to and end – innovate or die is the rallying call. So how can the NHS become an open system without losing the principles of equal access and free at the point of delivery?

The recently published *Origins of Wealth* (Beinhocker) sheds some light on what can be done and we have drawn heavily on the concepts which are summarised in the book.

First and foremost, Government must consider itself to be part of the problem and so, therefore, part of the solution. It has designed the system, so it is unfair and immoral to consistently criticise those working within it. It is the system that is the problem, not the people. Government needs to get out of the direct management of healthcare.

Secondly, forget about replacing the centralised approach with a market based philosophy – that will not work either. There are too many variables for the future to be predicted. Think open and closed systems – not central v market.

Thirdly, as a consequence, Government must redefine its role to become, as Beinhocker calls it, a "Fitness Function Shaper" [please accept our apologies for the phrase – it's not ours]. It should put in place Social Technologies (STs) that meet the two basic human preferences for collaboration and for fairness. For example, *Agenda for Change* is not a good ST – it reduces collaboration by reinforcing professional silos, and many individuals and professional groups do not consider the process and outcomes to be fair. Similarly, *Payment by Results* is also not a good ST – it might be different if it was based on money flowing with quality, not for activity; *Payment by Quality* perhaps?

Fourthly, Government should be clear about the values and norms of the NHS. Values such as fairness, and norms such as collaboration, individual accountability and trust.

Fifthly, Government must lead from the front by demonstrating that it trusts the people who make the NHS work. Studies have shown that societies with high levels of trust have greater wealth and health.

The business of delivering healthcare is too diverse, too variable, too personal and too fast changing to be directed from the centre. The current role of Government in health is dead in the water. How can a planned, centralised approach be fit for purpose when it takes a tremendous effort just to tread water? The answer is that it can't be.

Government cannot predict how healthcare will evolve, but it can help the NHS to evolve with carefully thought through STs. Of course, badly thought through STs will hinder and harm the NHS.

Have the government got the guts to let go?

© Monica and Terry Dennis, Healthcare Alliances, Cowbridge
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We welcome comments on this paper which:
- disagree with us
- agree with us
- amplify the points we make
- give a different perspective

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