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Authors

DAVID J HUNTER
LINDA MARKS

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What incentives exist for NHS managers to focus on wider health issues?

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Summary

Rebalancing the NHS from being primarily a 'sickness service' to one that promotes health is now firmly on the Government's agenda.

Increased media and public attention to the potential costs of 'epidemics' such as obesity, the two Wanless reports for the Government on the future of the public's health (Wanless 2002 and 2004), and the recent public health White Paper, *Choosing Health: Making healthier choices easier* (Department of Health 2004), have all helped refocus priorities.

Choosing Health accords the NHS the lead responsibility for public health and gives it new roles in providing advice and support services to help people make healthier choices. But bringing about this shift in focus will not be easy. Despite numerous and laudable statements promising to promote health and reduce inequalities, in practice, successive governments have been preoccupied by the pressures and demands of the acute care sector.

One reason is that public health has been regarded as part of the NHS, when the NHS should be seen as part of a wider system for promoting health and reducing inequalities. As a result, incentive and performance management structures have been skewed towards health care, rather than towards health interventions, and have overlooked other sectors with a role to play, notably local government.

This paper is the outcome of a research study that explored how NHS managers experience current incentive and performance management regimes and other factors that impact on them. In the light of the findings, it suggests how these might be realigned to bring about the desired shift in focus towards managing for health.

Putting health first

This paper forms part of the King's Fund's Putting Health First programme, which seeks to help broker wider debates about how best to develop an effective health system – one that gives priority to preventing illness and reducing health inequalities, not just to providing health services.

A key part of the programme is identifying the levers that might be used to bring about change. Targets, incentives and performance management regimes are important levers for governments and others seeking to engineer organisational and individual behaviour towards meeting policy objectives. This makes it essential to understand how they operate individually and in combination.

What did we set out to do?

Incentives are layered into the system and some exert more muscle than others (Coote 2004). This paper takes a broad approach, defining incentives as factors that promote change. Some of the most important include national and local targets, standards, inspection and regulatory regimes, and local performance and monitoring arrangements.

However, other factors also affect managers' ability to manage for health. These include resources and workforce issues, whether there is evidence on which to act, changes in funding flows and other policy developments.

To find out how all this is experienced 'on the ground', we conducted confidential, semi-structured interviews with national stakeholders and senior managers in four strategic health authorities (SHAs) and four primary care trusts (PCTs).

We chose these organisations because they were undertaking interesting work to improve health and tackle health inequalities. We also aimed to achieve some degree of geographical and socio-economic spread.

The 32 interviews took place in the summer of 2004, which coincided with the Government's consultation period for the *Choosing Health* White Paper. The qualitative analysis in this paper reflects interviewees' views in relations to a range of key themes, and outlines some pointers for future policy.

What issues did we identify?

The role of the NHS

Interviewees did not unanimously support the lead role for public health accorded to the NHS by the Government. Many suspected that the 'downstream' acute health care agenda would remain dominant, and that public health would never be regarded as core business, unless the culture of the health service changed in ways they found hard to imagine.

> *Certainly, in my 30 or 40 years in the health service, I would say this is the most positive moment we've ever had.*
>
> National stakeholder

> *Wanless is all very well, but when it comes to the election, it will be about hospitals.*
>
> Director of Performance, SHA

Targets

Since the mid-1990s, the health service has become increasingly subject to targets and regulation. Many of the NHS's 350 targets relate to health promotion but, with the exception of smoking cessation, few of our interviewees felt that these counted in the way that waiting-list or other acute-care targets did.

> *We're quite clear locally that if we fail our A&E targets, and our out-patient target, heads are going to roll. It's not quite so clear that if we fail our primary care or health promoting targets, heads will roll.*
>
> Director of Service Commissioning, PCT

This does not mean that public health targets should just be made tougher. Some commentators have argued that targets and performance management systems have no place in the health sector at all, because they cannot capture its complexity, while others have shown there are problems in having too many, competing or unrealistic targets.

Our interviewees were well aware of these concerns. They felt targets tend to measure what is easily measurable – which key elements of health promotion are not – and can take up an inordinate amount of time. Others felt that targets are a good way of concentrating effort, given limited resources.

Inspection and regulation

The NHS is now subject to inspection and regulation by a plethora of bodies. These include the Healthcare Commission, which has replaced the Commission for Health Improvement, and has a wider remit in assessing and monitoring public health, and the Audit Commission and the National Audit Office, which check stewardship of public funds.

At a local level, SHAs performance manage PCTs through local development plans and other tools, while local authority overview and scrutiny committees – and Patient and Public Involvement Forums – also have a role.

Performance management was a contested topic. Some interviewees felt it had delivered success in the acute sector (although what was meant by success, and at what cost, were contentious issues) so the approach should be transferred to public health.

> *The NHS is a driven organisation and unless things appear on the national agenda, people will not, on the whole, take them forward, because they don't have the time and space.*
> National stakeholder

However, this view also met strong opposition. Various reasons were given, but the general thrust was that the rigid, mechanistic approach to performance management adopted in the health service was fundamentally flawed and did not constitute good management.

> *The whole target thing is wrong. And while we have the target-driven system we have got, there's going to be some heavy performance management system. You cannot redesign [one] without the [other] – from the very top.*
> Director of Public Health, PCT

Other factors

- **Resources for public health** Interviewees felt public health resources and staff are spread thinly across health care organisations, and that networks developed to address these problems have been patchy and uneven in their impact. Many felt that public health leadership is largely missing, and that other skills, including project management and business planning, are in short supply.

  Although the Government likes to think that all the incentives make the difference, it's really the people. Investment in leadership is crucial, because if you get a good leader… they'll make things work.
  National stakeholder

- **The information base** Systems for monitoring the health of local populations are poorly developed, especially in key areas such as obesity, as is the evidence base for what works in tackling complex health issues and inequalities. This worried many of our interviewees, particularly chief executives and finance directors, who wanted to see a proper return on public funds. Others felt that lack of evidence should not be an excuse for inaction, and decisions could be made on the basis of 'good enough' information.

  I would like an intervention programme that does the following ten things… I estimate it will cost x and I estimate the health benefit will be y over the next five years. Now I can't do that at the moment.

  Director of Public Health, SHA

  I think most of the time you can see the picture. You should be able to work out what you need to do – you just need to go ahead and do it.

  Director of Public Health, PCT

- **Time factors** Interventions to improve the public's health are often long term in their effects, and this can make them unattractive to policy-makers looking for quick wins. Conversely, initiatives may be too short term to have an impact or move mainstream.

New policy developments

The Government has recently issued a raft of health policies that may support, or undermine, its commitment to a new focus on promoting health. New initiatives include:

- **The general medical services (GMS) contract** This new contract rewards GP practices for providing specified services, delivering quality and involving patients. Our interviewees welcomed it as a means of generating baseline data for public health (since activity must be monitored to generate payments), and wanted to find ways to maximise its public health potential. However, they also felt it currently emphasises chronic disease management, rather than primary prevention, and some worried that practices might abandon health promotion where they could not make it pay.

- **Payment by Results (PbR)** This new funding system, planned to be fully operational by April 2008, is designed to underpin patient choice by enabling money to 'follow the patient', thus rewarding providers for the activity they undertake. Our interviewees saw PbR as providing financial incentives for hospitals to increase activity. As a result, it was also seen as a spur to PCTs to control demand, in order to curb costs.

  If people keep going to hospital, because the rest of our system isn't working properly, we're going to be bust. It doesn't half focus your mind.

  Chief Executive, PCT

- **Practice-based commissioning** From April 2005, this will allow individual GP practices to apply to their PCT for an indicative commissioning budget. Our interviewees felt this raised questions about the role of PCTs, since it appears to undermine their ability to determine how their money is spent and to commission for population-wide services.

- **Choice** One of the Government's 'big ideas' for the reform of health care services, choice is envisaged as extending to public health in the *Choosing Health* White Paper. Our interviewees felt this could undermine their commissioning role.

  Well, choice is certainly not going to help the inequalities agenda… who answers the phone call or the letter? Who understands the information? Who chooses to go?

  Director of Public Health, PCT

Overall, our interviewees felt these policies had been developed in isolation and did not fit well together as part of a coherent 'bigger picture'. They remained focused on refashioning acute care, undermining the Government's stated commitment to public health.

What should change?

Our interviewees made a number of suggestions for improving targets and performance management in the future.

- **Targets** Interviewees felt that these should be: apolitical, plausible, fair to the organisations faced with them, locally owned, adjusted to different timescales, linked to broader strategies for health improvement and focused on disadvantaged groups and areas.

  I think I would prefer them to give me some big, generic targets to work with but accept from me a local plan for how we were going to get there.

  Director of Performance Management, SHA

- **Performance-management systems** Interviewees felt that these should: reflect the breadth of public health, reflect organisations' areas of control, work across sectors and be linked to equity audit.

  I want [regulatory bodies] to measure things that are measurable, things that are meaningful and not to measure things that when you measure them completely screw up another standard.

  Director of Public Health, SHA

However, our research suggests other policy issues need to be considered, particularly as the Government prepares to produce an implementation plan for its White Paper, *Choosing Health*. One of the key messages to emerge from this research is that it should not import 'target culture' wholesale into public health.

Aligning and strengthening policies and incentives

Not all policies and incentives are helpful in improving public health. There is already a surfeit of policies and incentives in this area, rather than a shortage, causing problems when they are unconnected or favour secondary care. Inconsistencies need to be resolved so a clear direction for policy can be articulated.

Every time something major happens at a national level... we just have to look at what it is saying about health issues. All the words in the world are of no interest whatsoever. What matters is the extent to which these issues are really placed in the key decision-making processes in the NHS.

National stakeholder

Although the rhetoric is starting to move towards health prevention, and particularly chronic disease management, the incentives in the system are still geared towards secondary care – that is, the hospitals.

Director of Service Commissioning, PCT

Public health governance

The incentive and regulatory structures currently in place, and the role accorded to the NHS in *Choosing Health*, encourage an approach to tackling major health risks and diseases that focuses on the individual. However, such an approach ignores the contribution that must be made across Government to achieving and sustaining the public's health and well-being.

We believe that a new concept, which we are calling public health governance, should be developed to encapsulate what the World Health Organization calls this 'stewardship role' of government. The concept of public health governance also has links with corporate and clinical governance, which aim to embed a systematic approach to addressing failure and delivering high quality in their respective fields.

Public health governance goes far beyond the NHS in its sweep. This raises, once again, the contentious issue of whether the focus of the NHS is too narrow to provide the leadership required in public health.

Proactive public health organisations

To make public health governance a reality, organisations both within and outside the NHS need to become proactive public health organisations.

We are not calling for a major structural reorganisation or the creation of new organisations to 'do' public health. Instead, we envisage a proactive public health organisation as any organisation that adopts a public health ethos and embeds it throughout its mainstream planning, funding and business processes, making public health everybody's business.

Public health leadership

Proactive public health organisations would instil a commitment to public health at every level from the board down. This highlights the need for more coherence and leadership in relation to the public health function.

Fewer levers, incentives and mechanistic approaches to performance management and regulation are required when there is real and sustained commitment from the top of the organisation.

The evidence base

Choosing Health shows that the Government is aware of problems in the evidence base for public health, and wants to address them. In future, the nine regional public health observatories will be expected to work closely with PCTs to strengthen their information-handling capacity.

A desire also exists for the academic community to become more closely involved in modelling cost-effective interventions. This is critical, because there is probably enough research describing problems, but not enough into what works.

> *We have levers, incentives and options just coming out of our ears here, and when nothing happens – we seem to have more levers and incentives.*
>
> National stakeholder

Conclusion

This study had a simple brief: to find out what incentives exist in the health service and how managers respond to them, with a view to suggesting ways of changing things to bring about a shift towards managing for health.

However, incentives are layered into the system and the total picture must be considered, as well as its component parts. This research shows a consistent message is needed to encourage management for health, backed by sustained political commitment and leadership at the highest level.

There are also lessons to be learned from the flawed, top-down, mechanistic approach that has characterised the target culture in acute care. The first of these is to avoid importing it unchanged into the public health arena. At the very least, the targets and measures that form the basis for Healthcare Commission inspections in the future should acknowledge the complexity of the health and inequalities agenda, and have the full support of those most affected by them.

However, we have argued that there is a need to go further and to develop and adopt a new concept, public health governance, and to embed it throughout the health system through what we are calling proactive public health organisations, which would regard health as mainstream business.

These concepts raise profound issues about the role of the NHS which, for most of its 56 years, has been almost totally preoccupied with the 'downstream' acute agenda. It is not enough to say that all that is needed is to refocus the NHS from being a sickness service to a health service, and that the way to do this is to come up with tougher targets and penalties for missing them.

More radical thinking is needed. Without it, the danger is that there will be another Wanless report in a few years' time, lamenting how little progress has been made in putting health first.

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