LIFE AND DEATH **Iona Heath**

Every day in every way we are getting better and better

Why the perpetual striving for perfection in healthcare?

Émile Coué de la Châtaigneraie (1857-1926) was a French psychologist whose publication *Self Mastery through Conscious Autosuggestion* was translated into English in 1922.[1] The key to his method, which he claimed was effective in the treatment of all maladies, was the repetition of a mantra-like phrase. He advised: "As soon as children are able to talk, make them repeat morning and evening, 20 times, the words 'Every day, in every way, I am getting better and better.' This habit will produce excellent health—physical, mental and moral."

Coué's optimism is admirable, but after an initial wave of enthusiasm in the early part of the last century his method fell into disuse, presumably because excellent health proved to be not so easy to create or sustain. Yet something of Coué's philosophy seems to live on in the imperturbable optimism of health policy in the United Kingdom. This optimism provides one of the last refuges of a seductive belief in the potential of logic and science to achieve the infinite perfectibility of human beings and human systems, despite all evidence to the contrary. Those in positions of power meddle constantly in the hope of achieving these hopeless ambitions. In so doing they make some things better but always, at the same time, they make other things worse. Every intervention may produce benefit, but it will also cause harm. The Payment by Results and the Quality and Outcomes Framework schemes for funding healthcare providers have illustrated this clearly, mostly by distorting priorities, minimising the importance of professional judgment in applying population based science to unique individuals, and generating a range of perverse incentives.

This constant imperative and the consequent illusion of progress frustrate increasingly dissatisfied patients, who continue to fall ill in unpredictable ways, through nobody's fault, and whose suffering can often be only partially relieved. It also demoralises and discourages doctors who work every day at the limits of medicine and know that they are being set up to fail.

The latest device to ensure that the NHS gets better and better is "commissioning for outcomes," which has been mandated by the new Health and Social Care Act. There is a rapidly increasing literature on this subject with, seemingly, each health service organisation and each health related interest group producing guidance. Searching the phrase on Google produces 14 300 results, and first on the list is Liverpool Primary Care Trust's *Commissioning for Outcomes: A Resource Guide for Commissioners of Health and Social Care*.[2] In their definition of the newly proposed processes the authors seem to have noticed the linguistic drift involved with each successive iteration of getting better and better: "There are many definitions of an outcome. In the English language, the word 'outcome' is often interchangeable with the word 'result' and this is appropriate in general conversation. However, when dealing with health or social care issues, to say that an outcome is the 'result' of what you do (intervention) is too simplistic. This is because as commissioners, and providers, we need to understand (or predict) what will happen as a consequence of the interventions we commission for. This helps us understand the effects of health and social care in the short, medium and long term for individuals, communities and populations." Yet clearly the ambition remains unrealisable and simplistic and illustrates the temptations of the linear reasoning of cause and effect.

Considering outcomes is clearly an improvement on paying for activity, but how much of an improvement? We can see what has gone wrong with previous interventions but delude ourselves that this time there will be no harms. Consider just a few examples of the nationally mandated outcomes, all of which are of course well intended. The first on the list is life expectancy at 75. This is not healthy life expectancy, and so it could easily serve to encourage ever more futile interventions. Another outcome is five year survival among people with breast, lung, or colorectal cancer. Each of these cancers is the subject of existing or proposed screening programmes, yet it is undeniable that screening causes harms through overdiagnosis and overtreatment and too often increases survival without affecting overall mortality.[3 4] My last example is the rate of admission of full term babies to neonatal care. Here the perverse incentive seems obvious and frightening.

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It is not wrong to want to improve the health service and the health of the population it serves, but the NHS also has to care for those whose health is inexorably deteriorating despite everyone's best efforts. How are these patients to be given the appropriate priority? So much of the policy direction seems to be driven by a Faustian ambition to control the threat of the unknowable future. Everyone must die, and life expectancy cannot be indefinitely extended. The attempt to prevent illnesses has led to the labelling of an ever greater proportion of the population as being at risk and to overdiagnosis and overtreatment. The health expenditure of the 34 countries of the Organisation for Economic Co-operation and Development is out of all proportion to their share of global disability life adjusted years. This is a form of greed—and it is that greed that is driving excessive health spending, not "inappropriate" admission of frail and sick people to hospitals.

There are downsides to Coué's mantra that were perhaps more readily understood by early 20th century parents than they have been by early 21st century health policy makers.

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