'Politically (In)Correct' Targeting: A Public Choice Analysis

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ABSTRACT

Targets have become a key instrument in UK economic policy. Numerical targets, such as the UK target for waiting list times for inpatient treatment, have a rationale in terms of public choice analysis. They appear to be premised on politicians' pursuit of getting elected. However, increasingly they are a target for criticism. This paper provides an assessment of targets in the public sector. It considers the rationale for adopting targets and actors' responses to incentives created by NHS targets. Whilst targets may make short-run political sense and therefore be 'politically correct', from other perspectives they look 'incorrect'. The analysis indicates that, in political processes, credibility gains contingent on target setting are likely to be short-lived and counter-productive.

1. INTRODUCTION

IN THE GENERAL ELECTION of May 1997, the Labour Party presented five bullet-point promises to the electorate. One of these was to deliver shorter National Health Service (NHS) waiting lists which, by order of presentation, took precedence over more mainstream political targets (eg. delivery of a strong economy). The Labour Party promised to reduce the number waiting by 100,000 during its first term of office. Why did the Labour Party do this? One prominent commentator noted later that: 'Targets are what New Labour has turned to in order to counter charges that it is no more than a political soufle' (Hutton 2002:26). He goes on to describe them as a 'brilliant economic and political device.' The target to reduce child poverty by 50 per cent by 2010 and eliminate it within a generation and the target to reduce traffic congestion by 2010 by 6 per cent below the 2000 level were two such targets. Hutton argues that targets define 'the agenda whilst simultaneously depoliticising it'. After all, what political opponent or citizen 'could be against such obviously worthy and objective goals'. To coin a phrase: 'the target is the instrument'. By May 2006 the Archbishop of Canterbury, Dr Rowan Williams, was clearly one prominent citizen setting his face against the 'worthy and objective goal', stat-

ing: 'A culture has grown up in the NHS over recent decades in which account-ability and accountancy have become seriously confused and false and destructive models of what counts as meeting targets have distorted a good deal of our practice.' (Williams, 2006).

How valid is this assertion? This paper applies public choice analysis to the claims for and against the worthiness and objectiveness of targets in the specific context of the NHS waiting list target; attempting to explain how they arise and how they contain the seeds of their own decay. Despite the focus on the NHS in this paper, many of the arguments advanced have applicability to the wider range of targets set and later abandoned or modified by New Labour.

In section two a process-orientated public choice analysis identifies why targets are adopted as instruments of public policy. Health care policy is an area where there may be legitimate debate about which actor's preferences are to be sovereign. For the vast majority of goods and services, consumer sovereignty can be accepted as the condition necessary for informed consumer choice to apply; from which some would simply assume they apply also to heath care. For health care there is a case for producer sovereignty where the 'scientific' experts who produce health care are viewed as the best judges of individual welfare with respect to that care. This perspective plays a role in section three. A government sovereignty model in the Paretian tradition would focus on governments responding, without self interest or guile, to correct merit-want type arguments and the standard market failure arguments so well rehearsed in the health care field (for a paper that considers what this might entail, see Cullis and Jones 2006.) Public choice analysts focus on government but insist that the actor depicted employs the same maximising calculus in the public sector as in the private sector. Whilst homo economicus is described with reference to three axioms: (i) the individual is 'rational'; (ii) the individual is egoistic; (iii) egoism takes the form of economic self-interest in narrowly defined terms (i.e. *homo economicus* is a personal wealth or income maximiser) (e.g. see Brennan and Lomasky, 1993), *homo politicus* might require (iii) to read '*homo politicus* is a vote maximiser'. In democracies voters elect politicians and politicians will try to enact policies that will get them (re) elected, otherwise they cease to be politicians. As Downs (1957:28) puts it: '...parties formulate policies in order to win elections, rather than win elections in order to formulate policies'. The next section considers what this perspective might mean for targets as a vote maximising policy in the public sector: votes, not income or wealth, are the relevant numeraire.

2. WAITING LISTS AS POLITICAL TARGETS: A PUBLIC CHOICE ANALYSIS

In recent decades reputation, credibility, time inconsistency, targeting and visibility have become terms in any policy economist's lexicon. Here the concepts are employed to establish whether they can fruitfully be used to explore the. economics of numerical policy targets in the context of social policy in general, and waiting lists and times in the NHS in particular.

The core of the argument is the simple idea that voter support is easier to come by if governments or would-be governments have a good reputation and adopt credible policies directed at visible problems whose solution costs are as invisible as possible. Reputation is not easily separated from credibility and here, following Weber (1991), reputation is viewed as a longer term concept and credibility more short term. Unlike Weber, reputation is viewed as the broader concept involving the electorate forming a probability that reflects the extent to which they view government as persistent and consistent in the pursuit of their stated policy goals. This probability is formed by observing and learning from the actual behaviour of government and as such is a more ex-post backward looking concept. Credibility is viewed as being a narrower concept, attached to specific policy targets, with the 'purchase' of credibility involving pre-commitment to a particular policy target. A binding commitment has perfect credibility; non-binding commitments partial degrees of credibility. Credibility is more of an *ex-ante* forward looking concept. Average credibility is effectively electorate-expected policy outcomes divided by government policy announcements, whereas marginal credibility is the change in electorate expectations divided by the change in policy announcement.

It is these concepts, alongside that of the target, that are employed here in an analysis of Labour's Waiting List electoral promise or pre-commitment. In 1997 the Labour Party had been out of office for 18 years and its label as a high spending and high taxing party would not, according to its leadership, capture the heart of the median voter. The creation of a manifesto and establishment of the credibility of the policies it contained was the task of campaigning and the early years of office. With credible policies a new reputation could be established. In this context it is worth quoting Hoopes (2001:131-2, emphasis added): 'For example, in 1992 citizens of Britain voted against the Labour Party despite the fact on the most important issues, voters rated Labour more favourably than the Conservatives. Rather than being ideological, irrational or grossly misinformed ... we can speculate that British voters in the 1992 election did not necessarily vote against their interest on key issues, but rather assessed that Neil Kinnock and the Labour Party could not deliver their promises on those issues. In other words, Kinnock lost on the *"credibility"* factor.'

2.1 Votes as the numeraire and the visibility problem

Electorate visibility has long been part of the public choice analysis of policy finance and outcome. Wagner (1976) explored the role of 'invisible' taxes in inefficiently expending public expenditure. Hettich and Winer (1984) examine a tax system that minimises the political costs of revenue raising. Lindsay (1976) considers the mix of 'outputs' produced by public enterprise as compared to market provision. In the market system, profit guides entrepreneurs to produce the quantity and quality of goods and services that conform to individual preferences. Monitoring is facilitated by profits that not only provide a clear measure of success or failure, but also act as an incentive to managers

to monitor effectively if they anticipate receiving a share of residual earnings. Lindsay points out that government enterprise is characterised by zero-priced output. This means that allocative information comes from an administrative process which, with the inability to use profit as part of the monitoring procedure, will be flawed. Adapting Lindsay's schema, there is a bias towards visible outputs or, in the case here, indicators, which are not only capable of easy documentation for government monitors, but also are easily verified by them.
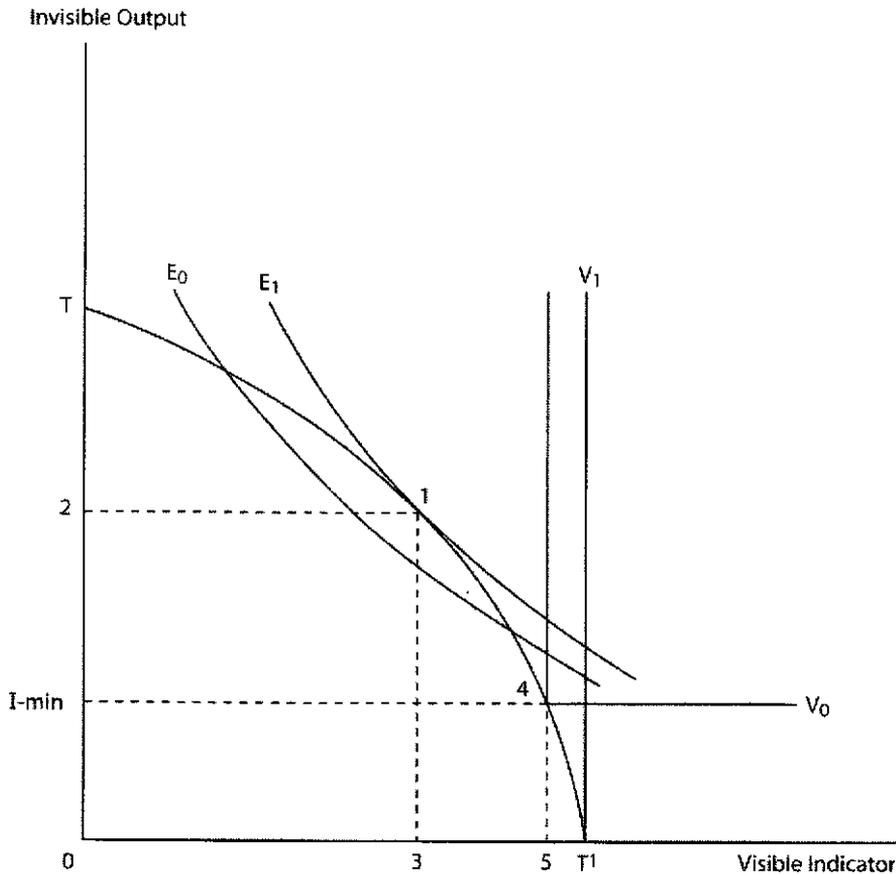

Figure 1. Voter Visibility Bias

An example is illustrated in Figure 1, where T-T^1 is a transformation curve representing the possible combinations of two characteristics of the health care process. On the y-axis is an invisible output (eg. caring and sensitive personal treatment of older patients) whereas on the x-axis is a visible indicator (e.g. recorded waiting lists and times). The curves labelled E_0 and E_1 are equi-price

curves and represent combinations of invisible output and visible waiting indicator that if 'monetised' would offer the same equilibrium price on the market. Market managers can be assumed to maximise revenue from any given outlay; hence the E-curves can be treated as managerial indifference curves. The market outcome would be point 1 on E_1 with 0-2 of 'caring and sensitive treatment' and a 0-3 value of waiting-associated indicators. Given that political managers will want to maximise votes for any given outlay, these curves are not the ones political managers would employ.

In the public sector it is characteristics of processes with voter visibility that matter. Equi-vote curves that show combinations of Invisible Output and Visible Indicator commanding the same electoral support in the political market place become relevant (and to all intents and purposes the political-manager's indifference curves). Where outputs are invisible to the electorate and by definition do not secure votes, the equi -vote curve will be vertical (V_1) and the Visible Indicator will be the focus of policy at T^1 (lower waiting lists and times are further away from the origin.) This is a corner solution with the valued but hidden Invisible Output being completely ignored and not produced at all. In the less extreme case where there is some visibility in the form of, say, ill-treatment scandals, the government will try to ensure some minimum level (labelled I-min) threshold of invisible output via periodic monitoring. In this case the equi-vote curve will take the form of V_0 and equilibrium will be found at point 4 with I-min of the invisible output and a 0-5 value of waiting-associated indicators. Here the context is a bias towards visible inputs, in the form of waiting patients. The visible waiting list occupies attention, but the welfare significance to be attached to it is less obvious and much less simple to report. Data on numbers waiting offer no insight into the costs of waiting or into the optimum list. The process of waiting for treatment in the NHS does not entail the same compliance costs as waiting in line. Individuals wait in absentia, on administered or managed lists (Lindsay and Feigenbaum 1984). It is this fact that makes it more difficult to produce estimates of waiting costs than simply reporting numbers waiting or the length of time they have waited. In this setting, one of the least-cost policies an out-of-office political party could adopt to try to secure votes is a global waiting list target. The policy focuses on a visible well documented and criticised aspect of the NHS and is virtually costless to state.

2.2 The credible target
It is argued here that the electoral commitment to waiting list reduction is a non-binding policy pre-commitment representing an ex-ante time consistent political equilibrium but not a welfare optimum. The relevant length of time horizon can be predicted to be short, as attenuated time horizons are a characteristic feature of political processes, underlined by the much quoted remark of a former UK Labour Prime Minister, Harold Wilson: 'A week is a long time in politics'. The relevant public choice scenario is captured with the aid

of Figure 2. Although waiting lists impose costs, their precise nature and magnitude are debated. However for the purposes here they are assumed known and to increase with numbers waiting (recorded on the x-axis of panel (I) of Figure 2). With a given NHS budget (B_0) efficient resource allocation involves maximising the social value of output and involves a positive waiting list. On the y-axis efficiency losses are recorded. Given the agency problem associated with the provision of medical care (see below) it is assumed these efficiency costs are zero when the doctor is a perfect agent (treating you in a manner that he or she would treat themselves in the same medical circumstances). The curve E—W describes the efficiency loss cost-waiting list cost trade-off given B_0.
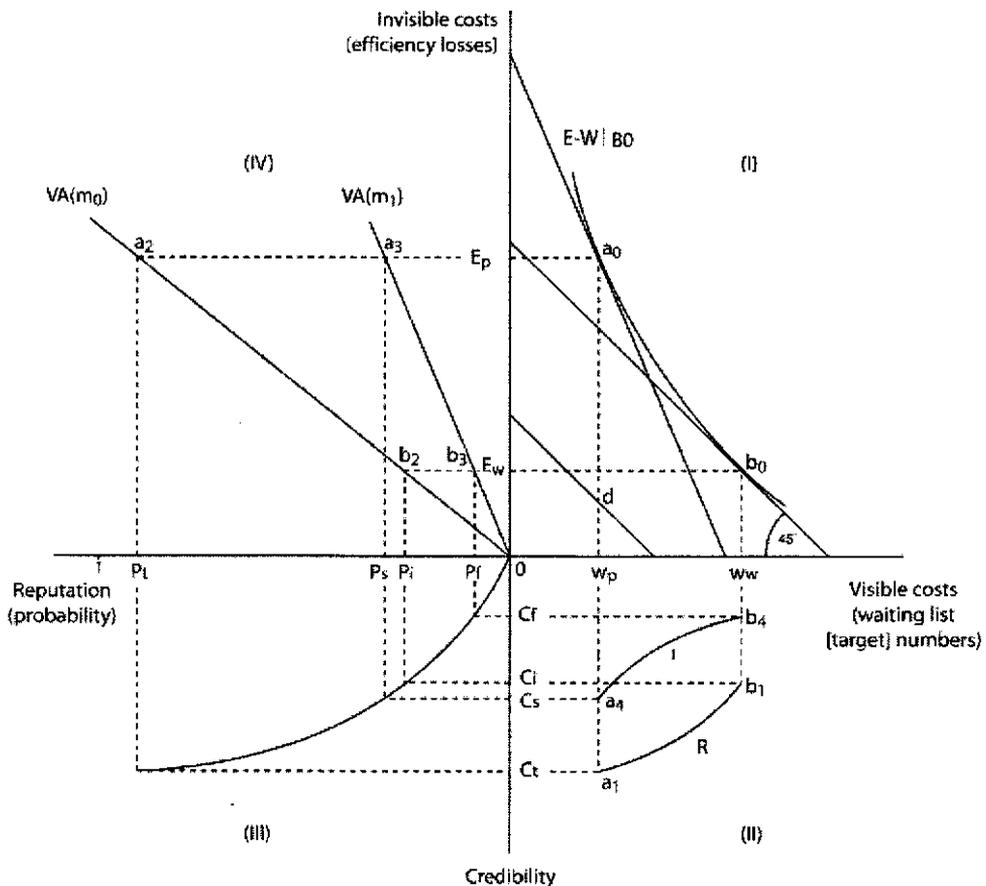

Figure 2. Target, credibility and reputation

It is negatively sloped on the grounds that for a given per-period budget, the numbers waiting can only be reduced if those being treated are done so in a less than perfect agency way — earlier discharge, less staff attention, fewer procedures etc. than the agent would see as ideal. The convexity to the origin is justified by the notion that it will be relatively easy to reduce the waiting list initially but, as the NHS tries to lower the waiting list towards zero, efficiency costs rise at an increasing rate.

Waiting lists (W) are a visible cost and efficiency costs (E) invisible. If the government's policy problem can be captured as:
Minimise

$$C = peE + pwW$$

$$\text{s.t.} \quad B = B(E, W)$$

Where:

   C = total costs;
   pe = the political shadow price or weights on E;
   pw = the political shadow price or weights on W;
   B = NHS budget;
   E = efficiency costs;
   W = waiting list costs,

a welfare maximising analysis would involve the costs being described as:

$$C = reE + rwW$$

Where re and rw are the welfare shadow prices or weights on E and W respectively. Their possible interpretation is elaborated on below in Section 4. Because of the visibility argument $rw<pw$ and $re>pe$. A political analysis sets an artificially-low waiting list Wp and correspondingly high efficiency loss Ep (associated with point a_0 in Figure 2 panel (I)) as compared to a welfare optimum and Ww and Ew at point b_0 in Figure 2 panel (I). (If only efficiency matters, $re = rw = 1$ hence the 45° line, however if there are equity concerns the welfare shadow prices may differentiate between those waiting and those being treated in the NHS, and the 'iso-cost' line slope will deviate from -1).

Panels (II) and (III) in Figure 2 connect the waiting list numbers target to electoral credibility and electoral reputation. Associated with inherited point b_0 in panel (I) is the credibility level C_i associated with point b_1 in panel (II) and the reputational probability P_i in panel (III). The relationship between credibility and reputational probability is assumed to be positive but exhibit decreasing marginal impact of credibility on reputational probability, so that the probability increases at a decreasing rate with credibility changes. If the government could establish a binding pre-commitment then, on announcement of the target, it would be as if the target was met and credibility would jump to C_t, associated with point a_1 and an instant reputational probability P_t closer to unity. In the absence of pre-commitment, the path of partial credi-

bility from b_1 has to be followed, hypothesised to have two branches. If the government makes sustained progress towards the announced target, the successive reductions in numbers allow path R to be followed. The initial movement towards the target is assumed to have a greater positive marginal impact on credibility than subsequent moves. The second branch comes into play when panel (IV) is introduced. In panel (IV) there is a voter awareness ray (labelled $VA(m_0)$), conditional on the level of media activity and a specific level of articulation (m_0) with respect to efficiency losses in this case. The slope of $VA(m_0)$ indicates that reputational probability is greater if greater reliance is placed on the relatively invisible efficiency costs compared to visible costs, given the level of media activity. Points a_2 and b_2 correspond to points a_1 and b_1 in panel (II) and a_0 and b_0 in panel (I). However the shadow prices can change. As Sen (1983) points out, democracy alters the internalisation of costs. A press looking for headlines allied with an articulate medical lobby can make the efficiency costs of the target much more visible, so that getting the 'right' cases treated rather than concentrating on artificial numbers target looks a superior policy.

In terms of Figure 2, if media activity rises from m_0 to m_1, $VA(m_0)$ rotates North-Eastwards bringing $VA(m_1)$ into play. Given panel (III) such a shift displaces the visible costs — credibility relationship so that point a_3 is associated with P_s in panel (III) and C_s and a_4 in panel (II). If the government fails and moves away from the announced target, the successive increases in numbers waiting causes path I to be followed. The initial movement away from the target is assumed to have a greater negative marginal impact on credibility than subsequent moves: it is the initial adverse movement that causes the most damage to credibility. Should the target failure be complete and the waiting list return to its original level, W_w then points b_3, P_f, C_f and b_4 are relevant. Notice C_f is below C_i and the targeting policy has damaged credibility and policy failure is worse than no intervention. This is a simple type of hysteresis effect whereby processes are not reversible, so that any increased voter awareness of the relatively invisible cost should be associated with a sharp fall of credibility and further, more modest falls if the waiting list numbers begin to rise. Given this framework, can supporting evidence be found to indicate its validity?

3. RESPONDING TO TARGETS: OBJECTIVITY AND WORTHINESS
Picking up on Hutton's statement quoted in the introduction about targets being "obviously worthy and objective goals", this section takes issue with the claims both to objectivity and worthiness.

3.1 Targets and objectivity
Archery employs a target, with an arrow either shot into it, whilst if the arrow cuts the black edge of one of the colours the higher value counts. Apart from

possible disputes about line-cutting shots, the process of scoring from the target looks objective. Numerical targets have about them this same apparent objectivity. Either they are met or not, as it is simply a matter of recording arithmetic facts and observations. However the world is not that simple. In the sociology of science there is a principle to the effect that 'distance lends enchantment'; that is, the further you are away from a particular issue, the more certain you are about it. For example, a person in the street tends to think a subject like physics is cut and dried, in that the nature of the world and universe is well understood by experts in terms of complex theories and irrefutable equations. However, physics contains a major internal contradiction in that the physics of the very small, quantum mechanics, deals with subparticles and a world of jumpiness whereas the physics of the very large, general relativity, relates to a world of continuity and smoothness. This is a circle that physicists struggle to square. Against this background of uncertainty about the physical world it is easy to question the objectivity of a numerical target in which sentient actors play a role.

Reviews of waiting lists reveal names of individuals whose admission has been delayed for medical reasons, whose condition has self-corrected, who have already been treated, moved away or died! Numbers waiting are inaccurate and, like everything else, require careful interpretation. Having set a 'politically correct' target, i.e. assuming W_w-W_p equates to cutting the NHS waiting list by 100,000, that initially was only partially credible, the government seeks to enhance its credibility by 'making it happen' in a context where medical decision making is likely to be closer to producing point b_0. Clearly there is an incipient moral hazard problem at work here that can potentially help the government but it is argued here does not. Once the government (the principal) states the target, agents, in the form of NHS decision takers, can undertake actions that alter the probability of the target being met. The extent of post-target opportunism depends on incentives. The probability of any target being met can be predicted to approach unity as the cost of missing (rewards for making) a stated target is increased.

With respect to waiting lists this has clearly been a factor. Once targets are set NHS managers have become anxious to meet them in any way they can. It has been generally documented that: records have been tampered with, 'accidentally' erasing names from computer lists; delays found in adding names to lists; hospitals offering patients appointments when it is known they have existing arrangements that mean they cannot make them; patients having been written to, asking if they still wanted surgery, with a tardy reply being used to justify removal from the waiting list. The economists' message that individuals respond to the incentives they face seems to have been fully received by NHS administrators and caused the Audit Commission to state in 2002 that the figures used to assess whether hospitals were meeting targets or not were entirely unreliable — so much for the superficial objectivity of numbers. Indeed, 'Professor George Alberti, the Government's emergency

medicine tsar ...confessed that the figures had been "gamed a bit"...' (Hinsliff 2003:2). The general documentation of these agent responses represents media activity increasing m_0 to m_1 and $VA(m_0)$ rotating North-Eastwards to $VA(m_1)$. Thus even if the target W_p was met, a_4 and C_s would be achieved rather than a_1 and C_t. The fact that all this has become well known indicates the potential credibility gain if the politically correct target was only C_i - C_s.

Focusing on experience with NHS waiting, Chart 1 indicates that numbers on lists have indeed fallen, by and large, in line with the stated policy, but this does not reveal the underlying processes at work or their desirability. Numbers waiting in England increased by 140,000 by the end of the Government's first year of office (consistent with a movement along path I towards b_4 in Figure 2). The (in-patient) waiting list initiative was correspondingly introduced in July 1998 (to coincide with the 50th anniversary of the NHS). This provided an additional £6 billion (i.e. additional to the existing NHS annual £44 billion budget) to be phased in over three years. However, the credibility of this initiative was soon undermined by criticism of the way that targets were pursued. In particular there was criticism of an increase in patients waiting to wait: after written referral by a general practitioner to a hospital consultant, patients must wait for an appointment to see the hospital consultant (before they can be admitted to the target in-patient waiting list).

Chart 1 Inpatient Waiting List Numbers 1979 - 2006 (March)
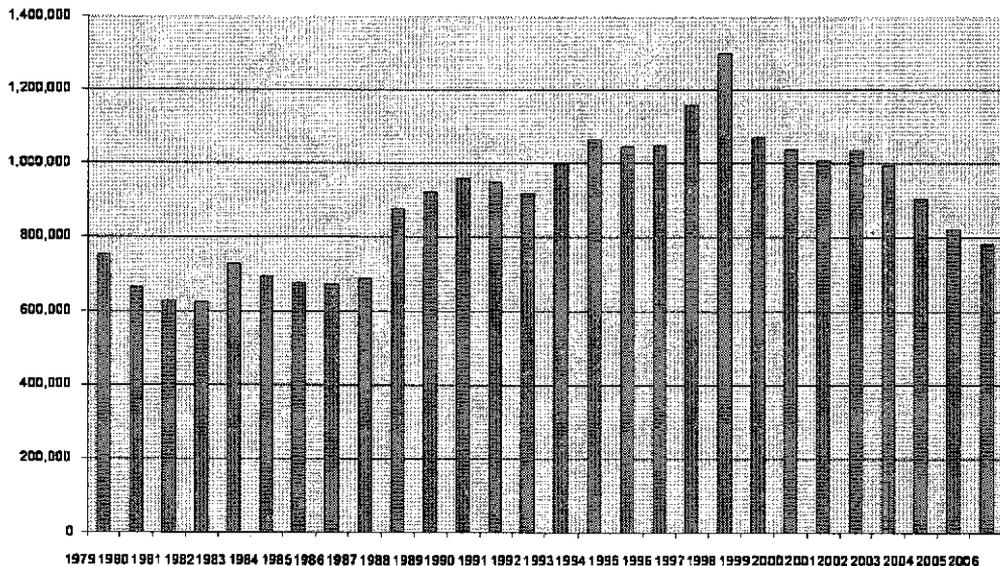
Source: Department of Health, Leeds, KH07

By March 1999 the number of patients waiting for a first appointment with consultants had grown. The Department of Health reported that, over the period March 1997 to March 1998, numbers waiting more than 12 weeks after written referral for a first appointment with a consultant increased by 86,000 (from 248,000 to 334,000). However, between March 1998 and December 1998 (ie. the nine months following the inception of the waiting list initiative) numbers waiting for more than 12 weeks rose by a further 133,000 to 467,000. It is not possible to explain the increase in the numbers waiting for the first appointment in terms of additional referrals by general practitioners. The Department of Health's *Statistical Bulletins* report that general practitioner referrals dropped during the Waiting List Initiative period from 2,286,000 (March 1998) to 2,283,000 (September 1998).

The explanation lies in the disincentive to add names to a target list. Statements by decision-makers were consistent with the criticism that distortion occurred because of the necessity to meet a numbers target. For example, the South Manchester Health Authority (cited in Mullen 1998) stated that, to meet targets, it is necessary to keep '... in-patient admission within specific limits, given the resources position...' and this '...means that it is not possible to accept all the referrals that are received...' (ACHCEW 1993:22).

Yet despite resources being directed towards hitting the target, it remained illusive (to have the target met naturally would involve increasing budget B sufficiently to move the E—W trade-off curve bodily to the left, so that a tangency at point like d would be attained. For the Labour Party however, controlling public expenditure was also a policy target and some extra resources had already been found. There seems little doubt that shadow prices changed. Persistent media attention and the information provided that made the efficiency costs of the target much more visible, meant that the sentiment of getting the right cases treated appeared a superior policy to concentrating on an artificial numbers target (see Hinsliff 2003). Individual cases of dramatically inappropriate care made headlines and it was to be the case that short cuts taken to hit targets were perceived as inefficient.[2] As the relative political shadow prices changed towards the welfare shadow price ratio, so the numbers target was played down and seems to have been all but abandoned, with an attendant loss of credibility and a damaged reputation. In the jargon, the numbers policy had been made time inconsistent, in that responses triggered by the target-setting itself meant it was no longer consistent with the underlying government preference for credibility and reputation and, hence, electoral popularity.

The focus here has been the recent promises of the Labour Government. However if public choice analysis is to have purchase it should apply to all political parties. Indeed, all major political parties are focusing on numbers waiting[3] and targeting numbers across a growing number of policy issues. For example, between 1979 and 1994 there were nine major changes in the method of constructing UK employment statistics. Eight of these changes served to reduce the numbers recorded as unemployed and it is difficult to escape the conclusion that it was an effort by the Conservatives not to be seen as the party of unemployment (Johnson and Briscoe 1995).

3.2 Targets and worthiness

Whilst targets have been stated clearly, on what basis have they been chosen? It is difficult to believe that 'cutting the NHS waiting list by 100,000' was anything other than a convenient, suitably large round number pulled out of the air to impress voters with The optimum size of a waiting list in an organisation like the NHS is a very difficult question to answer, so whether the existing waiting list was too long, too short or correct is not known. If this is accepted, cutting the list by a 100,000 may put it closer to or further away from the optimum value. In defining the optimum value, is consumer, producer or government sovereignty to be deferred to? Whilst the typical economist would look to Paretian welfare economics, the European Court of Justice (ECJ) seems clearly to favour producer sovereignty. In May 2006 they ruled that UK patients forced to wait longer than they should for NHS treatment are entitled to reclaim the cost of being treated in elsewhere in Europe. Where did the 'should' come from? The answer lies in the notion that a patient should not incur 'undue delay' in the receipt of treatment, so that a patient's waiting time 'does not exceed the period which is acceptable in the light of an objective medical assessment' (BBC News 16/5/06). The 'distance lends enchantment problem' questions whether an objective medical assessment can ever be identified. Nevertheless, the ECJ message was clear: even if politically-set waiting list targets could be met, this would not necessarily mean that a patient would not suffer 'undue delay'; Producer sovereignty mattered more than government sovereignty. The ECJ also added that waiting time targets must be set 'flexibly and dynamically' and reassessed if there was a deterioration in a patient's condition. Whilst this sentiment is difficult to quarrel with, it does not sit well in a world of stated and well publicised targets.

Is Dr Rowan Williams correct to state '...what counts as meeting targets has distorted a good deal of our practice.' (Williams, 2006)? Targets were of course central to command economy planning cycles and occur in private industry in market economies. The effects of using targets in planning have been widely analysed. Those subject to targets begin to game-play with the target-setters, conditional on the actual and predicted incentive structure in place. Does punishment or the allocation of additional inputs follow a failure to meet the target? Is there a payoff for reaching the target? Is there a bonus for exceeding the target? If there are positive inducements to exceed the target, are they offset if exceeding the target this period serves to raise the bar next period, making the achievement of future bonuses less likely? Target-setters typically want enterprises to reveal maximum achievable output from allocated inputs. That is their production function. But does this carry over from industrial production of visible verifiable output to something like the NHS? The idea of the production function in non-market contexts may become fuzzy and lose its mathematical precision on closer inspection (see Wolf 1979). The production function may well be uncertain or unknown but not unknowable. On the output side, activities may seldom lend themselves to natural units of measurement and therefore it

may become difficult to specify in a tractable way what output actually is (eg. care of the terminally ill). On the input side it may not be possible to specify the list of inputs needed, for example, to produce an older person who is 'well looked after and treated with dignity'. In short, in the NHS context, targets may be inappropriate policy instrument or in Dr Rowan Williams's (10th May 2006) words: 'A target obsessed NHS, managed with an eye to brisk traffic through its beds and reduction of expense, doesn't feel a very good place in which to have a reasoned and balanced discussion of assisted dying.'

4. CONCLUSION

The 'public choice' analysis of targets is an important illustration of Downs's (1957) prediction that decisions based on 'politically correct' objectives — the need for policy credibility and reputation — may not increase social welfare. It also highlights Buchanan and Tullock's (1962) criticism that electoral competition fails to deal with intensity of preference and focuses only on number of votes. The costs of premising policy on politically correct targets are evident. Waiting costs and waiting lists do not change monotonically; rent-seeking opportunities are difficult to avoid and there is a bias in favour of low-cost treatment. The more general conclusion is that the practice of promising to achieve numerical targets is a misplaced gesture. They are 'politically correct' to the extent that they win (or avoid loss of) votes. They are 'politically incorrect' in that, as currently conceived, even if it turns out that by the end of the parliament the targets are met, their achievement will say nothing about whether welfare has increased or decreased. The pursuit of such targets deflects attention from the more difficult (but potentially more productive) task of determining the appropriate social welfare maximand against a background of competing actor sovereignties. However, the incentive structure in the political market offers no inducement for politicians to grasp this nettle. The analysis offered here suggests that targets, except in the very short run where politicians in particular live, are neither a 'brilliant economic or political device'.

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2. For example, L Matless and A Wilson ('Surgeons slam operations on the continent', *Bath Evening Chronicle,* May 17, 2004) noted that 5 out of a cohort of 24 patients (on the waiting list of the Bath Royal United Hospital) sent to France for knee replacement operations now required further operations to solve problems created by the knee operations in France.

3. Of course, the NHS is the major remaining postwar Labour Party institutional inno-
vation and, as such, they are likely to be more sensitive to criticisms. Moreover, given
the income status of voters who are likely to go private, it is differentially Labour Party
voters that can be predicted to be on lists.

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