One year to save the NHS ...what would you do?

BMA chairman James Johnson kicked off 2007 by predicting the NHS had one year to dig itself out of the financial hole in which it found itself wallowing after a decade of reforms and five years of “unprecedented funding.” **Zosia Kmiotowicz** asks a selection of observers where they would start shovelling

Donald Berwick, president, Institute for Healthcare Improvement, Cambridge, Massachusetts, USA

Donald Berwick chooses not to dwell on the sense of distress and demoralisation that is circulating through the NHS at the moment, preferring to focus instead on the “tremendous amount of progress” that has been made in the eight years he has been watching the modernisation of the UK’s health services. Waiting lists are down and care for some clinical conditions is now more reliable than ever before. “It really has been quite a lot of progress and being able to take some pride and satisfaction in that is important for everybody,” he says.

Many of the health policy reforms introduced since 1998 should be viewed as temporary and experimental; given time, they too will be reformed or, better still, abandoned. “I am not a fan of competition and market forces as a route to improvements, but the government is insisting that they be tried. There is a big draw of NHS policy towards markets, competition, and new entrants,” Dr Berwick said. “I wish that the NHS would cease experimenting with additional suppliers of care. They lead to rapidly rising costs without much value for patients.”

There is huge potential in the NHS for integrated care, something that has so far failed to be captured by both NHS reforms and the recently introduced GP contract, but which would add value to services, he believes.

“I think that the most important relationships to develop further are those between physicians and nurses on the one hand and the management of the services on the other. It requires collaborative thinking. But the potential is there for truly integrated care at the health economy level. There needs to be better collaborative patient management between primary care

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trusts and hospital trusts, and this will lead to an improved total patient journey,” said Dr Berwick. “I doubt that this is not going to emerge from the current policy regime.”

Allyson Pollock, head of the Centre for International Public Health Policy, University of Edinburgh

The chaos currently engulfing the NHS is due entirely to its “marketisation” by the government and the transfer of up to 50% of public money to the private sector—through contracts for the private finance initiative (PFI); independent sector treatment centres; GP services; IT and other services; billing, invoicing and marketing, and use of management consultants, says Professor Pollock.

Increasingly, government has given away control of resource allocation and more and more of the NHS’s scarce funds are flowing into the pockets of shareholders, bankers, management consultants, and for-profit providers—away from the service. Nothing but a complete reversal of government policy will save the NHS.

“What is needed to save the NHS is a total abolition of the market and market mechanisms like payment by results, foundation trusts, and commissioning within healthcare, and the abolition of all contracts with private providers, including the compulsory repurchase of PFI hospitals,” says Professor Pollock.

Giving private providers a foothold in the NHS has allowed them to cherry pick treatments, services, and patients. The result has been to destabilise NHS services, leading to closures.

Professor Pollock advocates a return to the founding principles of the NHS—universal comprehensive and equitable free health care for all, delivered through a system of risk pooling. She recognises that certain weaknesses in the old NHS, such as public accountability, planning, and integration of services, would need to be strengthened.

“The NHS was designed to promote equity and integration. In contrast, the market which the government has introduced segments the risk pool into the profitable and the non-profitable patients and services. The impacts on patient care, access to services, training, education and quality, cost, and staff terms and conditions are devastating,” she says.

“We need to speak up against the market and the increasing privatisation of health care, with all its consequences. Not to do so will be catastrophic for the public health and return us to the gross inequities which were in place before 1948. It will be to betray those generations who fought so hard and worked so hard to give us freedom from fear,” says Professor Pollock.

Jennifer Dixon, director of policy, King’s Fund, London

Dr Dixon disagrees with Mr Johnson’s forecast for the short term future of the NHS, and she backs current health policy as “going in the right general direction.”

“I don’t think the NHS is going to implode in the next year,” she says. “The principle of introducing new incentives to try and improve performance is the right one.” She admits, however, that there are “teething problems” in other

areas of health services that need “modification or amelioration.”

In particular, Dr Dixon would like to see clinicians being encouraged to take more responsibility for the resources they use, something she believes should be linked to their contracts.

“At the moment there are no contractual obligations for GPs to manage the resources they are spending and influencing on behalf of their patients, and I think everyone should have that responsibility,” she says. “At the moment that is a glaring gap in the current contracts.”

Dr Dixon would also like to see GPs sanctioned for not commissioning services, or for doing so badly. “Not every GP needs to be commissioning, but they need to be cognisant of the resources they are spending and they need to have their practice scrutinised by clinical peers,” she says.

Steven Ford, GP, Haydon and Allen Valley Medical Practice, Hexham, Northumberland

“The rock on which fundholding and the current reforms have been based and on which the NHS is about to founder is the belief that it is or can be a business,” says Dr Ford. “The NHS never has been and never can be a business—it is what it says on the tin, a service.”

Further hindrances to a successful NHS are its organisational gigantism, its want of scope for sensitive local variation, and the unimplementable scale and complexity of the reforms, he believes.

Dr Ford would like to see “wholesale localisation” introduced throughout the NHS. “What I would favour is an abandoning of all pricing and invoicing and the promotion of the enduring success of a public service ethos. The measures of success for the NHS should be the steady decline of avoidable morbidity and mortality, a reduction in lost work days, continuous optimisation of all therapeutic usages, resilience in crisis, patient satisfaction, and an exuberantly productive highly motivated workforce. Simplicity, delegation, and non-interference will yield the prize.”

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Parliament and the Department of Health cannot be dismissed outright, however. They should establish a broad brush statement of requirements for the NHS, but keep it brief—ideally expressed “in less than ten thousand words.”

The Treasury should divide, per capita, the existing NHS funding among county-sized units charged with the delivery, at primary, secondary, and tertiary level, of the statement’s requirements, says Dr Ford. These units should then have carte blanche to establish services that work locally, based on needs assessments. They would be run by top quality managers, local representatives of patients and professions, local MPs, and councillors, with others co-opted as required.

The role of the strategic health authority would be to guarantee probity, safety, and delivery of services. “A coherent, locally responsive service, answerable to users directly is preferable to a national business failure with a demoralised workforce,” said Dr Ford. “Let diversity flourish and to hell with the market.”

Peter Carter, general secretary, Royal College of Nursing

Were he given the reins of the NHS for the next 12 months, Dr Carter would focus on four key areas to guarantee the service’s survival. First he argues that the comprehensive spending review must “sustain the levels of

investment needed to continue the progress made since 1997 in raising health outputs and improving clinical outcomes.”

Another priority area is deficits, where he calls for an end to short term cuts and the development of a long term recovery plan. He also believes that “central government should give local trusts more time, flexibility, and support so they can clear their debts,” and he urges ministers to safeguard education and training budgets and fund a guaranteed one year employment and preceptorship for students.

On the third key area, reform, Dr Carter said that all new policies should be costed and tested; that all stakeholders should be properly consulted and fully involved; that equality of access, universal coverage, and care that is free at the point of need have to be safeguarded; that modernisation must enhance, not undermine, collaboration in healthcare; that reforms should put patients first by always being clinically informed, never cost-driven; and that “the NHS must be supported and sustained as the centrepiece of our healthcare system.”

Lastly, Dr Carter’s attention would focus on the workforce he represents. “We must improve nursing recruitment and retention levels to tackle the underlying nurse shortage and defuse the nursing retirement time bomb. We should deliver a pay settlement for nurses that rewards their skills, professionalism, and dedication, rather than penalises them with a cut in pay, as currently proposed by ministers. And we need to stop treating our NHS workers like overheads to be cut and start treating them like assets to be valued,” he said.

Chris Ham, professor of health policy and management, University of Birmingham

Professor Ham believes that the slogan “Culture eats strategy before breakfast every day” rings true in most organisations, not least the NHS. “Fixing the problems of the NHS requires shifting from a culture of compliance with externally imposed targets to a culture of commitment in which the principled

motivation of staff is leveraged to deliver improvements for patients,” he says. “This requires every NHS organisation to give priority to engaging doctors and other clinicians in the next stage of the journey of reform.”

The reason for emphasising cultural change, rather than strategy and resources, is simple. “In people centred organisations like the NHS, many of the solutions to the problems that exist can be found among the staff providing the service. The challenge is to harness the energies of staff in bringing about service improvements and to align these energies with those of the organisations they work for, and patients,” says Professor Ham.

“If clinicians are best placed to lead change, then managers have a critical role in ensuring that it happens and that staff have the skills and resources to bring about improvements,” he says. “The paradox of professional service organisations like hospitals and primary care practices is that they are staffed by a mix of innovators and conservatives. The stimulus of high quality managers is therefore essential in supporting the innovators and challenging the conservatives to improve care for patients.”

The NHS needs to learn from organisations like the John Lewis Partnership that show what can be achieved when employees see that their actions benefit themselves, the organisation they work for, and customers. “Developing a partnership model in which doctors and other staff have a real stake in the success of their organisations should be the long term goal.”

Zosia Kmietowicz is a freelance journalist