Reforming the NHS reforms

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Rather than improving efficiency, the reforms imposed on the NHS have increased bureaucracy, reduced patient choice, limited the range of core services, and led to inequity of treatment. In this paper I examine how the medical profession might help to solve these problems. Priorities must be set for health care since no government can afford all the possibilities offered by medical science. It is essential to forge a consensus of patients, carers, professionals, the public, and government if a system of priorities is to be equitable and just. We also need to be able to measure quality of outcome in health care. This requires consensus on what is the desired outcome and the development of appropriate guidelines, audit, and performance review. This is primarily a task for the health professions supported by management and by adequate investment. Basically, the government must reinstate the three traditional values of the NHS—equity, consensus, and regard for representative professional advice.

Case for the prosecution

It gives me no joy to say so, but the BMA was largely correct in 1989 and '90 in its predictions of the consequences of the NHS reforms. We anticipated that they would damage the integrity of the NHS and would lead to a fragmented service. We predicted increased bureaucracy, although we could scarcely have foreseen its scale.¹

The purchaser-provider split, with its perverse philosophy of winners and losers, was foreseen to diminish rather than to increase patient choice, to limit the comprehensiveness of core services, and to force some patients to travel out of their locality for treatment. Rather than money following patients, patients have had to follow the money, until it runs out, with little relevance to relative need. Resources remain inadequate to cope with the demoralising effects of demographic change and social deprivation. The BMA is not alone in highlighting such problems. The press chronicles daily a dismal catalogue of problems and official rebuttal. Informed criticism includes problems with the preparation of contracts² and the jeopardising of arrangements for patients requiring specialised treatment.³

The National Association of Health Authorities and Trusts has reported district managers' claims that the reforms are going too fast,⁴ and the Medical Defence Union has drawn attention to the potential legal consequences of patients being discharged prematurely in the effort to achieve higher turnover rates.⁵ Much press and official investigation has been devoted to levels of waste, particularly in relation to computer systems.⁶ The House of Commons Public Accounts Committee has expressed concern about ethical standards in the public service,⁷ including the NHS. The King's Fund, in the fullest evaluation so far, has concluded that the reforms have done little to improve the quality of service or patients choice.⁸

The aim of this paper is not, however, to look back but to look forward and to seek an understanding from the origins of the current problems as to how the medical profession might contribute to their solution.

Case for the defence

The NHS is unusual, if not unique, in several respects: historically, having been conceived in a wartime union of faith in a pacific future married to the vision of a welfare state fit for heroes; economically, in acceptance of corporate responsibility for the health of all the people; ethically, in enshrining the principles of the Judaeo-Christian and utilitarian traditions; and politically, in achieving a broad consensus among the people, their government, and the professions who care for them. This remarkable phenomenon, tailored to a national need and a national creed, inadvertently but inevitably nurtures a comforting mythology of self sufficiency of philosophy if not always of practice.

This fond illusion has been shattered by two simultaneous forces, both originating from outside Britain. One is the *Health of the Nation* policy,⁹ commendably if belatedly introduced in 1992 to implement the 1985 targeting strategy of the European Regional Office of the World Health Organisation.¹⁰ This strategy derived in turn from the global Alma Ata Declaration of 1978 in which the WHO and Unicef joined forces in the call for health for all, which involved a drive for healthy lifestyles, priority for health promotion and disease prevention, and the reorientation of health care systems towards primary health care. The other force for change, sadly predating the *Health of the Nation*, was the imposition of the internal market reforms foreshadowed by *Working for Patients*¹¹ and made law by the NHS and Community Care Act 1990. This massive experiment, inspired by a different culture and tradition, was denied the benefit of a pilot trial of any kind. The medical profession's offer to cooperate in such obvious research was curtly dismissed as a sly professional ploy designed to delay the entry to the promised land.

No health care system is free of problems. Much recent publicity has focused upon the United States, where per capita spending on health is more than double that in the United Kingdom but where 15% of the population are without basic health cover. Last year the Alberta government announced a 20% cut in health spending phased over four years, mirroring a similar announcement by the Australian government in 1991. Nearer home, the Germans have introduced severe controls on prescribing costs, and the Danes have placed restrictions on referrals.

THE EXTERNAL TRIANGLE

All health care systems manifest evidence of a three sided health care problem. The first element of this problem is the need to secure reasonable resources for health care. With economic recession health care has to struggle alongside education, industry, transport, and defence for a share of the gross national product. That share is determined by political forces and by the perception of governments of the electoral value or otherwise of investment in health care. We are fortunate in the United Kingdom that the NHS is still viewed politically as a valuable national resource. Ultimately, however, the public and the health professions are distanced from the discussions that lead to the announcement of the annual NHS expenditure proposals.

The second element of the health care problem is the issue of priorities. No government or nation can hope

to afford all the technologies that modern medical science can offer. Public tolerance of personal suffering is probably at an all time low, encouraged by emphasis on consumer rights and individual choice as enshrined in the patient's charter. As Kierkegaard observed, in every choice there is a sacrifice. If sacrifices are not to be borne by those least able to articulate their need there must be rational debate about "posteriorities" as well as priorities. This principle holds whatever the level of funding. It is no accident that the most publicised experiment in seeking an explicit set of health care priorities has been conducted in Oregon, one of the United States' richer states. The conference held by the BMA, BMJ, and King's Fund in March 1993 on priorities and health care showed how essential it is to forge a consensus of patients, carers, professionals, the public as a whole, and government in such a process.¹² If the essential values of equity and justice are to be served, consensus is vital.

The third element of concern is the quality of the outcome of health care. Having decided how much to spend and what to spend it on, everyone concerned has an interest in ensuring that the outcome is what is required by the purchaser. To achieve this, we must meet two conditions. Firstly, as in priority setting we need mechanisms for reaching a consensus about the issues. Secondly, we need a substantial investment of commitment and energy in developing appropriate outcome measures supported by acceptable clinical guidelines, routine audit, and peer performance review. This is primarily a task for the health professions, supported by management.

Solution and resolution

The resolution of these issues requires a resolve by government to reinstate the three traditional values of the NHS—equity, consensus, and professionalism. The current situation seems to conspire against this solution because the opposite of all three factors prevails. The principle of equity sits ill with an ideology that values competition more highly than cooperation. Equity, the leading criterion of the WHO strategy of health for all, has been deliberately driven from the NHS by the alien ethic of competition for patients in both primary and secondary care.

Aristotle's dictum that there is no greater injustice than to treat unequal causes equally, challenges us all to seek a new consensus. Admittedly this is no easy task in a divided society that seems today to value self above all else. In the drive to satisfy self interest we have lost the value of selflessness. Professional involvement in the crucial decision making processes that determine priorities and quality is essential, but the medical profession—in common with others—has seen a sustained assault on its integrity and values over the past few years. The calculated disregard of representative professional advice, which began with the new general practice contract's insistence on "independent" advice and which is starkly illustrated by the current

process of replacing regions with outposts of the central bureaucracy, has had the desired effect. Management has been taught so effectively to distrust the voice of the medical profession that it is now ironically reluctant to heed the newly enlightened urgings of the Department of Health to restore effective professional advice to the purchasing process at local level.^{13,14} The abandonment of equity and consensus and the marginalisation of professional advice have had a malignant, paralysing effect upon the body corporate.

An appeal

The BMA looks to government to restore the three key values which inspired the founding of the NHS and which were the hallmarks of the respect in which it was held worldwide. We must reform the reforms to reinstate equity of access and to strive for equity of outcome in health care. We must value consensus above competition in public service. The litmus test of such resolve in the NHS is consensus about core services which were envisaged in *Working for Patients* but which have become a forgotten cause. Core services should be purchased through local arrangements in which local people have an informed and effective voice. Rolling contracts extending over three to five years, which were also envisaged in *Working for Patients*, would present a welcome haven of stability in contrast to the wasteful, divisive, and time consuming annual round of contracts which currently bedevil any attempts at longer term planning by either purchasers or providers.

Good professional management requires the full participation of consumers and purchasers alike. Above all, government and managers must recognise the value of professional judgment and involvement in the management of the health care system.

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A MEMORABLE PATIENT

Walking through angina

I had no idea that it was possible to "walk through" an episode of angina pectoris until William described it to me. He was a man of 48, member of a fell walking club, and most weekends he would be off tramping the Lakeland fells. Recently he had begun to feel a pain in his chest after he had been walking for about five minutes. It persisted for about 10 minutes and then, as he continued to walk, the pain went away and did not recur for the rest of the day. He thought it was "wind." I wasn't so sure. His

electrocardiogram was normal but a consultant physician told me that the history was characteristic of ischaemic heart disease and that the patient was "walking through" attacks of angina. William was advised against fell walking.

Out on the fells one Sunday I chanced upon William, surrounded by his club mates, 600 m up on High Street. He was dead.—T I WATKINS is a retired general practitioner in Cumbria