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OBSERVATIONS

NHS REFORMS

How to lose friends and alienate people

Why are the NHS reforms causing so much unrest as to threaten complete paralysis?

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Although the current NHS reforms in England have been developing over the past 20 years,[1] their strategic direction has been consistent and inexorable. Three basic elements have emerged: the separation of provision from procurement (to try to reduce the acute sector's supply-side pressures on demand); the consequent introduction of some degree of contestability to further reduce complacency among providing organisations; and the devolution of decision making as closely to the patient interface as possible to increase clinicians' sense of personal involvement in making these decisions.

Naturally, the mechanisms have changed and evolved, but the underlying principles of the reforms have managed to weather changes in government, in health secretaries, and in financial circumstances. Indeed, those same principles have underpinned health service reform internationally. So, at first glance, it may seem surprising that the current reforms are causing enough unrest to threaten them with complete paralysis or, worse, with becoming so distorted by realpolitik that their well established momentum is lost completely. Why has this happened, and what can be done about it?

There are probably only two (albeit significant) key issues of contention where the substance of the changes is concerned:

- What level of competition can the NHS encompass without risking destabilisation?
- What kind of accountability is appropriate when procurement is led by clinicians who are themselves providers (especially when viewed by other, less involved clinicians)?

There is no definitive answer to the first, but there are lessons to be drawn from both common sense and experience drawn from other sectors. Common sense tells us that although it is probably necessary to take small risks to engender innovation, it would be foolish to endanger any service whose consequent failure would threaten the viability of the whole organisation. Thus, few developed countries would privatise their entire police force or educational system. However, significant aspects of both of these are usually driven through competition and market forces[2]; much work is done by private companies whose desire to reap personal benefit drives the introduction of innovation and inventiveness, qualities traditionally harder to nurture in the public sector in any country.

The trick is to put out to tender those services where there are either enough alternative providers to allow seamless replacement should failure occur (say transport or payroll, in the two sectors described) or where the risk of failure doesn't raise the possibility of political blackmail (as was the case where investment banks were seen as "too big to fail").

In health service terms, such conditions already exist, and many similar "marginal" services in the NHS are now contracted from the private sector. However, there are also many clinical areas where such conditions also pertain: as long as the expertise and technology are not so unusual or expensive that they cannot be replaced, there is no operational reason why an effective commissioner should not be able to keep providers and potential providers on their toes without putting any service at risk of failure.

Of course, the converse is that we should not put out to competitive tender any service or system whose size means that failure would cause serious disruption (as happened with the banks). Thus, we should be wary before we contract an entire hospital service from the private sector without ensuring that we could cope should the company providing that service cease trading for any reason. Hospitals in a local area should be able to select areas of their own choosing to subcontract to external providers; services such as physiotherapy, orthopaedic surgery, and cardiac rehabilitation (among many others) could all be put out to tender while remaining within the "golden rule" of ensured continuity and minimal risk to viability.

This leads us neatly to the area of accountability, where the NHS has traditionally been hoist on the petard of "measurability." The fact that medicine is an imprecise science, where cause and effect are often hard to link, is generally well

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known; nevertheless, in our current era of governance and accountability we find it necessary to develop measures that demonstrate transparency and legitimacy. Not only are these often reductive and misleading (just how closely do trolley waiting times reflect the overall quality of patient care, for example?), they also lead to artefactual issues of internal conflicts of interests.

In the examples of outsourcing cited above, hospital trusts retain responsibility for providing all the services mentioned (whether already outsourced or in the hypothetical examples); common sense suggests that it should be left to the accountable organisation to decide how to provide services, always remembering that the consequences of service failure (that is, poor outcomes) remain with that organisation.

Insisting that the mechanisms of service delivery should be as publicly accountable as their outcomes generally leads to stultifying bureaucracy and inertia, as well as increased inefficiencies and high transaction costs. As long as trust boards understand that they remain accountable for clinical and financial outcomes, how the internal transactions are managed should concern the external commissioner only in terms of their legality and safety.

And if that holds true for subcontracting within the acute sector, shouldn't it be applied to primary care too? Ultimately, the putative GP consortiums are no more than providers of services under contract to some form of NHS commissioning board (whatever arrangements finally go through) with the responsibility to provide all care for their registered populations. In that role, they may be expected to have the freedom to choose which services they provide themselves (where expertise, technology, and quality markers allow) and which services are commissioned (for which read "subcontracted") from other agencies that are likely to include NHS trusts, other providers, and perhaps internally provided alternative models too. As long as consortiums are held to task for acceptable outcomes, effective finances, and positive patient feedback, and the "golden rules" of procurement risk are applied, does it matter whether money is withheld from traditional hospital providers?

The consortiums will need the freedom to enact this role or else lose the clinicians' involvement completely. Expectations have been raised and dashed so often that there is a great deal of cynicism in the GP community (the problems enacting practice based commissioning illustrate this well[3]), and so promises made will have to be kept on this occasion or else any further initiatives of this kind precluded for a generation.

Of course, a degree of consortium maturity will be needed before the system runs entirely smoothly, and this timing issue forms the first of the "process" problems that beleaguer the new round of reforms. It is a conundrum of all political life that although inclusivity and "ownership" are key to any successful change, particularly where autonomous professionals are concerned, the longer and more inclusive a change process sets out to be, the more likely it is to be diluted into homoeopathy; the obverse of this is that dramatic, paradigm shifting change risks raising so many antibodies and so much resistance that no change at all can take place.

The current process seems to have reaped the worst of both of these; introduced as a radical change and perceived as revolutionary in a way that belied its uncontentious principles, the 2010 white paper *Equity and Excellence: Liberating the NHS*[4] has certainly created antibodies and resistance, although it must be said that previous attempts at NHS reform have evoked similar responses. The recently introduced "pause" is unlikely to increase anyone's sense of ownership,but will ensure a dilution of the principles to the extent that the well established and generally agreed direction of travel may be lost completely.

The lesson to be learnt is that these contradictory factors should formally be taken into account at the very start of the process and a campaign planned that minimises the resistive forces, not the opposite. Imperfect though it was, there may be lessons to be learnt in this respect from the manner in which the Darzi consultation process was carried out.[5]

Linked to this is the notion of professional ownership and responsibility. One of the phenomena of the early 21st century is the perception that every individual controls his or her own destiny irrespective of the needs of others. Indeed, this precept lies at the heart of the newfound "patient centredness" of the NHS. This idea of individual autonomy has long been part of clinical training (especially for doctors) and is seen as a useful aspect of a successful doctor-patient relationship; the problem then arises of how to inculcate a sense of corporate responsibility towards the wider NHS among doctors without asking them to give up their individual independence.

Human nature is such that people generally "invest" of themselves only if they have a personal stake in the outcome of a task; such stakes may be emotional or financial or linked to status and peer perception, but without these we are unlikely to care. We all spend "our" money more carefully than we might spend someone else's cash, and the challenge in health reforms is to find a way of making clinicians feel that it is "their" resources that they have to spend wisely, not "just" the Treasury's funds. All the moves towards clinical engagement in the management process over the past two decades have been aimed at achieving this, whether through GP fundholding, primary care groups and primary care trusts, or the new GP commissioning consortiums.

In the current iteration of the reforms, despite the financial climate getting colder by the day, the public emphasis has still been put on the financial elements of "ownership" being given to GPs, when this has been more often perceived by GPs themselves as government trying to pass the buck of service rationing over to them. Power and responsibility need to be seen to be aligned, along with the ability to benefit in some way (and not necessarily financially) from accepting them. To paraphrase Marshall McLuhan, "perception really is reality" where change management is concerned.

The final lesson to be learnt in terms of the process of change concerns the British perception of public services in general and the NHS in particular. The sense of egalitarianism that pervades our society is still surprisingly strong, as is our resentment at any hint of inequity. The term "private sector" is inexorably linked in the public mind to ideas of elitism and advantage, so invoking the private sector as the putative saviour of public services needs to be handled with considerable sensitivity, especially by a largely Conservative government. It is no accident that most of the "marketisation" changes that have occurred in the NHS have happened under a Labour government: they could take for granted support for such action among Tory voters and so only had to persuade their own (relatively) friendly followers of the virtues of their approach.

Andrew Lansley and colleagues have to persuade a part of the electorate that is inherently hostile to their ideas to welcome a notion that appears to undermine all its values in terms of public sector, equity, profits, and elitism. To carry that off needs inspired and informed political, managerial, and clinical leadership with a human touch, all of which currently seem to be in short supply.

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4 Secretary of state for health. Equity and excellence: liberating the NHS. Department of Health, 2010.
5 Secretary of state for health. High care quality for all. Department of Health, 2008.

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