



## **The NHS Plan: A view from 30,000 feet**

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I title this reflection *A View from 30,000 Feet* to signal my limitations. I do not have a great deal of the detailed knowledge and experience that one ought to have to be considered an 'expert' on the NHS. Understandably, people with years of experience in the trenches may have reason to feel that I don't know enough to comment on the NHS. However, I do remember from my days as Assistant Secretary of Defence in Washington in the 1960s, that we paid a great deal of money for views from 30,000 feet and higher, and that people in the trenches benefited from the information. Both perspectives may offer valuable insights.

### **Additional resources**

*The additional resources the government plans to devote to the NHS are clearly, indeed desperately, needed. I don't see in the Plan any danger of overshooting the appropriate amount. The expanding range of beneficial medical technologies is awesome. Many of them are making large differences in people's lives. Think of total hip replacement for painful, disabling, arthritic hips or bypass graft surgery that is prolonging and improving lives. Think of the substantial reduction in deaths from heart disease that have been achieved in other countries. The extra resources, used well, could save lives, relieve*

money, and the government was not spending nearly enough. But, as the Prime Minister said, "...the NHS needs fundamental reform if it is to provide the standard of care that people deserve in the 21<sup>st</sup> century."<sup>1</sup>

Every health system has a problem linking the flow of funds to people's preferences. In the US, cost-unconscious insured patients and doctors paid fee for service do a lot more than people would demand if they had to pay for services themselves. Cost conscious consumer choice among care systems might ameliorate this. The July Plan's acknowledgement of serious and persistent under funding suggests the British model has the opposite problem. It would be worthwhile thinking about ways to correct it.

### **Admitting serious deficiencies**

*I particularly appreciate the Plan's honest admission of the serious systemic deficiencies in the NHS. The list is not short. For example "The NHS is a 1940s system operating in a 21<sup>st</sup> century world. It has: a lack of national standards, old-fashioned demarcations between staff and barriers between services, a lack of clear incentives and levers to improve performance, [and] over centralisation and disempowered patients. [p.10] Or "the burden of heart disease is*

under-provides cardiac surgery so waiting times are too long. Currently, there are some 450 coronary artery by-pass grafts (CABGs) per million population carried out in the NHS per annum ...against a National Service Framework target of at least 750 per million..." [117] Or "But some people wait much longer than this [average]-- up to 18 months for inpatient treatment...."[103]

These frank statements suggest that the authors are sincere and serious about exposing the problems and proposing solutions. It is refreshing and helpful. *A frank statement of the problems makes it possible to have a serious non-partisan non-ideological discussion of how to improve things.* Previously, statements about obvious deficiencies caused one to be considered impolite, as if insulting the Queen, or to be branded an arch-conservative. Frank discussion of the problems is now less likely to be seen as merely a partisan attack or an ideological statement.

I mentioned some of these problems in my writings, but I felt inhibited by the culture of defensiveness and national pride that sheltered the NHS from realistic debate.

The document does not mention the recent well-publicised quality disasters such as at the Bristol Royal Infirmary. Perhaps the authors felt that these had been publicised enough already.

Nothing I say should be taken in any way to suggest we necessarily do things better in the US. The American system of health care is a paradox of excess and deprivation. And we have a devil of a time getting even basic quality improvement practices (such as computerised physician order entry in hospitals) into practice. We all have our problems.

### Continuous Quality Improvement

One of the foundations of the Plan is that "The NHS will ensure that services are driven by a cycle of continuous quality improvement."

I believe this is the right idea. I wrote about it in my Rock Carling Lecture. In fact, it is

sustaining a large cultural change to one of continuous innovation, transparency and openness, sharing ideas for improvement. *This is a big challenge. Just talking about it does not make it happen. The government was wise to characterize this as a 10-year project.*

CQI has many features that ought to make it appealing to health professionals:

- It is based on scientific method: measurement, testing of hypotheses, data analysis;
- CQI appeals to the best in us, to the desire to improve. It should fit well with the public service ideals of NHS people;
- CQI is opposed to the culture of 'name, blame and shame' that has been all too prevalent in the politically charged NHS environment. One of Deming's principles is 'drive out fear.'<sup>3</sup> *CQI is based on the belief that the source of errors is usually not bad or negligent people. The cause of most failures is poorly designed systems that can be improved. It is the job of management to improve systems and processes.*
- CQI emphasises continuous training and improvement of skills.
- CQI entails devolution of power and responsibility to local front line professionals.

The Plan's emphasis on improved working lives in the NHS is very much a part of CQI. It is hard to expect staff to care and respect patients if their own employer doesn't care about and respect them. I had the privilege of meeting many excellent and highly motivated NHS professionals. If CQI succeeds, their values will prevail, and vice versa.

*The main problem in this scenario is that there is little or no competition for patients in the NHS. CQI is very hard to motivate and sustain in any case. People in US businesses who have succeeded in transforming their companies speak or write of 'near death experiences' as they realised their competitors were within reach of destroying them. For the Japanese car and electronic manufacturers, CQI was a matter of national economic survival.*

*CQI is very hard to start. And I think it is much harder in a public sector monopoly because there is no competition, no 'near death experience' to*

introduced by political control (see below). Also, CQI is hard to start in health care, especially when it comes to getting physicians involved. CQI is *not* a way of life in most American hospitals. In fact, it has reached relatively few, and then fairly recently. The Mayo Clinic, one of our icons of high quality, got into CQI 8 or 10 years ago (Though it had a culture and structural features that have promoted quality improvement since its founding in the Nineteenth Century.) Most US hospitals aren't there yet.

I visited two NHS hospitals where there was substantial progress along the path toward CQI. The Plan mentions other examples. So it isn't impossible. But it does take exceptional leadership.

There are important elements of CQI in the Plan:

- A new system of 'earned autonomy' will devolve power from the centre to the local health service for those providers who are serving patients well.
- Electronic medical records.
- Service process redesign: targeted expert support to spread best practice.
- The performance assessment framework applied to NHS Trusts. There will be an annual report card in association with the Audit Commission.
- Benchmarks.
- Incentives (financial and non-financial).
- Break down barriers among staff. Maximum use of talents of the entire NHS workforce.
- Break down barriers between primary care and community health services.
- Modernise education and training. Continuing education for all.
- Mandatory reporting of adverse events and a single database. (It is an extremely delicate problem to make sure this does not become politicised. I am impressed that all the top health professionals who developed the Plan should recommend it.)

*The NHS Plan describes a rather elaborate CQI process, driven by inspectors, grades ('green light, yellow light, red light'), benchmarking*

individuals, etc. *It presupposes good data, so that the grading system does not get bogged down in arguments over the data (an inevitable phase in any improvement process), but it might help to create better data by creating consequences of data and for inaccurate or non-reporting.*

*This 'red light, green light' business looks a bit childish, almost embarrassing. It looks too much like 'name, blame and shame.' Publicly 'redlighting' a whole hospital is likely to cause all sorts of problems. Local citizens won't want to go there. Will other hospitals have the capacity to care for them? Red lighting a whole hospital might be inappropriate. Some hospitals have excellence in some departments and poor performance in others. I wonder whether it wouldn't be better to let the data on quality of specific services speak for themselves. I do wonder whether there really will be transparency such as publication of Risk Adjusted Measures of Outcomes (RAMO) by hospital. I argued for this in my Rock Carling Lecture. The Plan does not make a clear commitment to it. I think the technical problems can be overcome, but the political problems with the doctors may be harder. I think publication of RAMO data, which are objective, can be more effective than 'red light' designations, which are bound to be subjective.*

The inspectors, the rewards and punishments, and the benchmarks are meant to drive improvement. *It is hard to say how well it will work. Very few if any public sector monopolies have sustained CQI, but then not a lot of private sector competitors have either! The force and continuity of the drive for improvement is uncertain. What could one say to a cynic who asks "What will sustain this through changes of minister and government?" It might work well. Within the confines of a public monopoly without consumer choice, I am not aware of any better strategy. The question is whether more fundamental structural change is needed.*

### Centralisation?

The Secretary of State writes: "Local hospitals cannot be run from Whitehall." He's right. Yet the document has a very

inspectors, rewards and punishments relative to those standards. And the Minister will personally be riding herd on it to make sure it happens. *It just looks like a lot of top-down surveillance and command and control. And it is hard to know how to change that without more fundamental change in the whole structure of the NHS. After all, the Secretary of State is 'the customer.'* A model driven by the Minister, rather than responsible consumer choice and competition, will be centralised.

*There is a danger that top-down bodies will decree 'best practice' and stamp out local creativity and initiative. Will the inspectors be able to spot a really good new idea that is different from official best practice, or will they just be checking for compliance with official best practice? There are likely to be several best ways of doing things, depending on circumstances, and they will be constantly changing.*

### **Less bureaucracy or more?**

The Plan creates several new public bodies including the Modernisation Agency (which encompasses that National Patients' Action Team, the Primary Care Development Team, Collaborative Programmes, the Clinical Governance Support Unit, the NHS leadership Centre, and the Beacon Programme), task forces on Waiting, Mental Health, Older People, Children, Inequalities, etc., the NHS Appointments Commission for non-executive directors who presumably are supposed to do some thinking of their own, the National Clinical Assessment Authority, the UK Council of Health Regulators, the Patient Advocacy and Liaison Service and more.

The government assures us "that more money goes into frontline services rather than into bureaucracy," and are "already committed to save £1 billion "as a consequence of abolishing the internal market." *This is a very dubious figure.* Politicians' claims to cut bureaucracy are usually pandering to a popular misconception that all money not spend on frontline services is wasted. Yet 'bureaucracy' is needed for information systems, performance evaluation, quality improvement, operations research and

much more. *Bureaucracy was needed to prepare The NHS Plan. The challenge is to be sure the bureaucracy produces good value for money and that its tasks are done in the most efficient way. A 'zero bureaucracy' NHS in which frontline workers would be without information and analyses to tell them what works best would be very wasteful.*

Jennifer Dixon and Steve Dewar recently described this problem. *With all these apparently overlapping bodies, who is in charge, both nationally and locally? As they observe, "Red' light organisations will be subject to a bewildering gang of possible bodies who will be able to manage their performance. These include the Modernisation Agency (who will hold their share of the performance fund), the Commission for Health Improvement, local green light organisations, or some other body (unspecified) that could tender to take over management. This is messy and predatory performance management. Who is in charge locally?"*<sup>4</sup>

*I think we could all do well with less claims of 'cutting bureaucracy', and more making sure we have good management systems, including good information systems and people acting on the information to improve the NHS.*

### **Problems of political control**

I have alluded to some of the problems that political control makes for management of an enterprise. Of course, the NHS and health policy generally must be politically controlled in the best sense of the term, i.e. that the values of society, democratically expressed, are encoded in health policy and programmes. Critics of market models are wont to point out the many kinds of 'market failure' that prevent the free market from reaching a socially optimal outcome. This needs to be balanced by a recognition that politicians, in their perpetual quest for re-election, introduce chronic 'government failures' that bias public sector outcomes in undesirable ways. The list includes:

- The government faces a basic conflict of interest between its purchaser interest, on behalf of patients and taxpayers, and its producer interests. Because people tend to

governments are biased in their favour, at the expense of patients' interests.

- Short-termism as the political time horizon runs only to the next election;
- Legislators who have been known to intervene in hospital decisions to create special benefits for political supporters;
- A culture of 'name and shame,' as politicians seek to pin on their opponents blame for everything that goes badly;
- Preoccupation with inputs, not outputs: hire more nurses, build more beds, etc. The Plan speaks of waiting lists and times, but rarely of outputs;
- A preoccupation with cosmetics which grab headlines, rather than spending on fundamentals which do not;
- Making decisions for ideological reasons not well connected to practical reality;
- Innovation in the public sector is inhibited because rewards/punishments for success/failure are out of balance;
- Politicians tend to use anecdotes rather than statistical data because anecdotes are cheaper to collect and more easily understood by politicians and the public than statistical data.

None of this is to suggest that the democratic process expressed through politics shouldn't shape the broad outlines of the Health Service. It must. But it does suggest that, *just as we have reached a widespread consensus that political management and control is not the best way to run coal, steel, banks, airlines, electric utilities, communications or transport, so are we likely to come to realise that the political process is not the best way to manage the operations of the Health Service.* Government should be the responsible purchaser, planner and regulator of services for the public, unconstrained by its role as supplier.

### Information technology

Good information is fundamental to the improvement of the quality and economy of NHS operations. Good data are needed to measure and evaluate outcomes and efficiency, to plan improvements and to measure progress. Without vastly improved information, *and people trained and motivated to use it, nothing else will do much good.*<sup>5</sup>

There are some references to Information Technology in the Plan. The amounts to be spent look small: "We are already investing £200 million in modernising IT systems. As a result of this NHS Plan, there will be an extra £250 million invested in information technology in 2003/04..."

This might be compared with the \$1 billion per year (£700m) that Kaiser Permanente, America's leading Prepaid Group Practice and non-governmental delivery system is spending on behalf of the 8 million people it serves, or roughly 20 times as much per capita. (This includes hardware, software, training and staff. It is of course quite possible that the Plan's £250 million refers to a shorter list of contents.)

In any case, 'information' is a lot more than IT. Information is a matter of motivating people to report accurately and completely. For this to happen, the information must be relevant to people's own work, and information reporting must have consequences. *The Plan is very weak on incentives and processes for motivating accurate and full reporting. Lack of information and use of it in decision-making is a major weakness of the NHS.*

For example, hospitals might report discharges more consistently and accurately if part of the money they receive were tied to the receipt of complete discharge abstracts, attested as to accuracy and completeness by the attending physicians. This is the case in the American Medicare programme which pays hospitals per case completed by diagnosis related group (DRG). And outpatient encounters might be reported more accurately and consistently if physicians were paid, in part, on the 'relative value units' generated, as recorded on patient encounter forms. ('Relative Value Units' are numbers, usually based on costs, used for comparing the value of different physicians' services.) It wouldn't have to be complicated. But reporting does have to matter.

### Empowering consumers

The Plan document says "patients must have more say in their own treatment and more

How is this to be achieved? The list is impressive for its length:

- Greater information for patients. (This is a good idea, but if they have no choices, it may not do much good.)
- Informed choice of GP. (It takes more than information to make choice of GP work for patients. Among other things, it takes an adequate supply of GPs who are really interested in adding patients.)
- Booking every hospital appointment and elective admission. (This will be a huge improvement.)
- PCGs will be able to move service agreements from one hospital to another. [89] (However, elsewhere in the document, [56] we are told “Competition between hospitals was a weak lever for improvement, because most areas were only served by one or two local general hospitals.” Research by Professor Carol Propper did not confirm this view.)<sup>6</sup>
- Strengthened protection for patients in the form of standards of care, mandatory reporting, and various inspectorates and enforcement agencies.
- A new patient advocacy service or Patient Advocacy and Liaison Service (PALS) [91].
- Rights of redress.
- Patients’ views on governing bodies. (How are these ‘patients’ selected?)
- Financial rewards for trusts linked to the results of an annual National Patients Survey. (This is quite promising and resembles something HMOs do regarding patient satisfaction with doctors in the USA.)
- Scrutiny by local government.
- Patients and citizens and lay inspectors on CHI review teams, a Citizens Council to advise NICE, etc. and abolition of community health councils.

*When one stacks it all up, it looks pretty heavy and not obviously congruent with the promise to eliminate bureaucracy. Do they protest too much? The authors must have felt some discomfort over this issue. It all looks like a costly substitute for consumer choice and competition, the most powerful incentive to motivate providers to respond to patient preferences.*

## Doctors’ pay

I do appreciate that the Plan discusses the deficiencies in the way consultants are paid and the need to reform it so that those who do the most for the service get paid the most. I believe that most consultants work very hard and above and beyond the call of duty, and I think it is important not to insult them and treat them like children. However, there is evidence that a few abuse the system, and that this reduces the amount of service to NHS patients.<sup>7</sup> So it makes sense to measure performance, as with Relative Value Units, and to have standards for minimum performance. If doctors do more, they ought to be paid for doing so.

The proposal that new consultants could do no private practice for seven years sounds coercive. That may not be the best way to increase the supply of high quality doctors or to foster good relations with the private sector. *Private practice can help the NHS by making doctors more willing to work for the NHS for low pay, and by relieving the NHS of the burden of caring for private patients. The problem is to make sure the NHS defines and gets what it pays for in all cases.*

## The private sector

The new approach to the private sector described in the Plan and in the Concordat<sup>8</sup> is potentially a very important step in the right direction, possibly the most important change in the Plan. It illustrates a welcome reduction in the government’s commitment to outdated ideology. It is a courageous change because it risks conflict with public employee unions.<sup>9</sup> *A government keen to modernise needs to know that an important trend in business management today is to outsource functions that can be done better by someone else than in-house. The NHS already buys a significant amount of services in secure psychiatric and long term care as well as acute care to relieve winter pressures. But until now, the present government has viewed negatively the private sector in health care. The Concordat signals a fundamental change in attitude. “Health Authorities in their strategic leadership role will be expected to ensure that local private and voluntary health care providers are involved in the processes designed to develop the local Health Improvement*

towards planning the use of private and voluntary health care providers, not only at times of pressure but also on a more proactive longer term basis where this offers demonstrable value for money and high standards for patients.”

*The government might get much better value for money in pathology, imaging and dialysis and other services from a competitive private sector. And it might be worthwhile to explore with the private sector the creation of a few specialised high volume hospitals to perform procedures that are chronically backlogged, such as hernia repairs, cataract removals, and joint replacements. The Shouldice hospital in Ontario is famous for its proficiency in hernia repairs, which is all they do. The Private Financing Initiative (PFI) might be extended to some private sector management of hospital operations.*

Doing a good job of purchasing hospital services from the private sector will not be a simple task. The NHS will need to learn how to define the ‘products’, how to pay for them, and how to measure and monitor results. The government will need to develop a uniform payment methodology comparable to Diagnosis Related Groups (DRGs), Ambulatory Care Groups (ACGs) and the like. Money could then follow patients. Consumer choice would become more of a reality. Patients could go where they and their GPs agreed. *The very fact that a significant number of suppliers are from the private/voluntary sector will force the government to develop the pricing, payment, and performance measurement methods that ought to exist for public sector suppliers.*

In implementing this change in strategy, the government will have to be able to assure private providers that, if they meet their contractual commitments and give good value for money, they will make a decent return on investment. Otherwise, private investors won’t be willing to commit their capital, and voluntary providers won’t be able to generate the capital they need to finance expansion and improvements.

As the Concordat says, “Regardless of where NHS patients are treated, existing charter and quality standards will apply.”

improved) uniform national quality reporting standards applicable to public providers.

*Over the long run, this policy, if it is successful, will gradually transform the government’s role from that of monopoly supplier of services to that of purchaser on behalf of patients and taxpayers. The NHS will become the primary payer, planner, specifier of services and monitor of their quality, and the private and voluntary sectors will increase their role as suppliers of services. The government would no longer be responsible for everything that goes on in hospitals. Gradually, the government would be able to escape the present conflict between its roles as purchaser and provider and the NHS would evolve to a true ‘purchaser-provider split’ with clear roles for each party. A more competitive market to serve NHS patients could emerge.*

## Conclusion

I will watch with great interest to see how the Plan changes actual performance, and whether its targets are met. I hope very much that it works. If it does, I will want to learn how the NHS motivated and sustained CQI because it will be making history in the fields of public management and quality management if it can do this in a public sector monopoly. The quality and dedication of its people are an important factor making for success. A truly first class NHS could teach the rest of the world a great deal. But the odds of success are not so high as to warrant stopping serious discussion of the alternatives.

## Notes

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<sup>1</sup> The Prime Minister, NHS Modernisation. House of Commons Hansard Debates for 22 March 2000.

<sup>2</sup> Enthoven AC. *Reflections on the Management of the National Health Service: An American looks at incentives to efficiency in health services management in the UK*. Nuffield Provincial Hospitals Trust, Occasional Papers 5, London 1985.

<sup>3</sup> Deming WE. *Out of the Crisis*. Cambridge MA: MIT-CAES, 1986.

<sup>4</sup> Dixon J, and Dewar S. “The NHS Plan: As good as it gets—make the most of it. *British Medical Journal* 2000;321:315-316 (5 August).

<sup>5</sup> Enthoven A. Modernising the NHS: A promising start but fundamental reform is needed. *British*

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<sup>6</sup> Propper C. Market structure and prices: The responses of hospitals in the UK National Health Service to competition. *Journal of Public Economics* 1996; 61:307.

<sup>7</sup> Yates J. *Why are we waiting?* Oxford: Oxford University Press 1987, and *Private Eye, Heart and Hip, Surgical Consultants, the National Health Service and Private Medicine*, London: Churchill Livingstone 1995.

<sup>8</sup> DoH, *Commissioning arrangements in the new NHS. For The Benefit of Patients: A Concordat with the Private and Voluntary Health Care Provider Sector*, 28 November 2000.

[www.doh.gov.uk/commissioning/guidance.htm](http://www.doh.gov.uk/commissioning/guidance.htm)

<sup>9</sup> Public employees shouldn't mind if someone else will be competing for their services.