

A short and partial history of NHS reform in England

For over two decades governments in many countries have been concerned about increasing costs of health care. This paper provides a light hearted history of some of the major governmental attempts to contain costs and improve productivity within the NHS in England in that time period. It suggests that all of these policy initiatives, whatever the colour of government, have been strongly influenced by a particular way of looking at the world and that using alternative paradigms could lead to very different approaches to policy.

In 1983 Roy Griffiths, a business man with considerable experience of a service industry, commented, about the NHS, that 'If Florence Nightingale were to be seen today she would be using her famous lamp to try to find out who is in charge'. He advocated replacing the District Management Team, of District Administrator and District Medical and Nursing Officers, with a single General Manager. He explained this as removing 'management by veto', which was how he described the requirement for consensus among DMT members if decisions were to be taken. In a short while administrators and their profession disappeared and a new one was born. Retired Rear Admirals and Wing Commanders competed with business people and those (soon-to-be-ex) administrators for the new general management roles. Now that the problematic 'veto' was no more and there was a single person in charge, the blocks to imaginative provision of services were removed, with improvements in quality and reductions in costs naturally taking place.

Except that they didn't.

Flirting briefly with the idea of dismantling the NHS, Margaret Thatcher's policy advisors decided the problem was lack of incentive to improve organisational performance, and that this could be generated by the creation of an 'internal market'. The 'purchaser / provider split' in which identification of health needs and commissioning of services to address them was separated from service provision, was followed by provider units becoming Trusts, no longer managed by a District Health Authority but selling their services to them, and to GP fund holders, as 'money followed the patient'. Naturally, now that not only had the veto been removed but managers and their organisations were energised by having to compete in a market, services were very quickly and imaginatively redesigned to increase quality and reduce costs.

Except that they weren't.

When changes took place they were at the margins (faster, more reliable discharge letters, shorter waiting times for a few patients) as a result of specific demands from fund holding GPs. There was considerable change, as there always had been, in clinical practice as a result of new technologies and also as a result of a newfound emphasis on 'evidence based medicine', but the design of services as a whole remained resolutely familiar.

With GP Fund Holding unacceptable to the incoming Labour government, Primary Care Groups and then Primary Care Trusts were formed, in which GPs and other primary care professionals would influence commissioning decisions (which replaced purchasing decisions) through membership of the Professional Executive Committee which was 'the engine room' of every PCT. At the same time the government invested very considerable additional funding and, to ensure it would not be wasted, imposed access targets for a range of services, that were so far from contemporary practice that most providers found them highly challenging, and a requirement that all parts of the system live within their financial means. A culture of 'personal accountability' was encouraged, in which individual managers were held accountable for the performance of large complex interdependent systems, which was another way of energising managers to focus on organisational performance (this time against the targets). This combination of money and reforms led inevitably to the thoughtful redesign that provided better care, shorter waiting times, and lower costs.

Except that they didn't. Even when expertise in service redesign was fostered in a central Modernisation Agency, which seconded excellent health care professionals from specific specialties to generate best practice service templates, local clinicians often resisted implementing them. Targets were, largely, met through additional expenditure and, as there were other calls on the new money (commitments to additional services, new technologies, pay increases, new buildings and plant ...) most organisations found it increasingly difficult to stay within budget.

So, if this wasn't the answer what would be? If removing management by veto, giving managers the power and the energy to implement change, informing commissioning decisions with clinical opinion, and ensuring sufficient redesign expertise within the system, does not lead to change on the scale that is needed, what would? Suppose all hospitals were autonomous Foundation Trusts which entered into binding contracts with powerful, well informed commissioners and they were allowed to succeed or fail according to their ability to offer services of high quality and low costs. Suppose too that patients chose for themselves the service provider they preferred, and that there were a national tariff for payments so that efficient providers were rewarded and inefficient ones penalised, then it would be in the interests of managers and clinicians alike to redesign their services and cut out waste and focus on quality. This is the system described in the Monitor view of in which transactions between commissioners and trusts are seen as 'the core of any health system'.

It is too early for the results of these changes to be apparent, so we are only able to speculate whether this will work. We can suggest however that its success relies on certain prerequisites and these are that:

1. Clinicians behave like professions in many other industries, recognise a management hierarchy and do as they are told
2. The press do not have a habit of reducing complex situations to simple fights between 'goodie-baddie' caricatures in which they almost inevitably cast doctors as goodies and managers and politicians as baddies
3. MPs do not mind negative coverage in the media
4. The unremitting emphasis on organisational performance does not impede the thinking across organisational boundaries that will be necessary for service redesign to yield highest quality lowest cost care
5. Health care organisations in England to behave in a completely different way from those every where else. When similar incentives have been introduced elsewhere (e.g. the US) they typically trigger an initial reduction in costs through greater efficiencies which is then followed by a larger and more sustained increase in costs as hospitals try

to gain competitive advantage either by adding 'kit' (e.g. the latest scanner, DVDs in private rooms) and/or by securing a regional monopoly which allows them to increase prices and/or 'game' successfully with funders.

Is there another way of looking at this?

A different history of the same events

The lens through which the health care system has been viewed in all these initiatives is a managerialist (or perhaps MANAGERIALIST¹) one, strongly influenced by the economists' view of the world. This is so much part of the zeitgeist that many of us have forgotten there are others.

A sociologist, for example, or a political scientist, may not have observed 'management by veto' in the old District Management Team, but a process that reflected the difficulty of reconciling a number of different interests, where some of the stakeholders hold a status that makes them ill prepared to accept challenge and leads others to find it difficult to make that challenge. In such a situation they would have predicted that any general manager would find it just as hard as the DMT to address any issues other than a few hotel services. They would have predicted too that increasing the organisational incentives (and penalties) by introducing a market would lead to a dash for cash in which acute units sought to develop new facilities and attract more patients, with the higher status centres being more successful in this than others, so that organisational energy would not be vested in redesign of existing services but in adding to them. This would also result, they may have suggested, in tertiary centres either receiving more than their 'fair share' of resources or feeling aggrieved that they hadn't.

Their forward gaze might also have indicated that the higher status secondary and tertiary care clinicians and their management colleagues would perceive PCTs, and especially their managers, as 'low calibre' – whether they were or not. This would be exacerbated, our crystal ball gazers might have speculated, by the fact that because posts in PCTs would always hold a lower status than those in the acute sector, they would not attract people determined on a fast track to the top, however rapidly salaries in PCTs were escalated. PCTs would struggle, they may have predicted, to make an impact. Would they have gone as far as suggesting that acute and foundation trusts would see PCTs off – persuading the department of Health that they had 'failed'? Perhaps. They would certainly have foreseen that all but the most self confident of SHAs would continue the age old practice of supporting acute sector managers in any dispute with primary care or community care colleagues. As a result they would have foreseen that while PCT folk would be able to see that financial pressures on their health economies were leading to short term fixes and fudges they would be unable to do anything about it. They may also have foreseen that PCTs, unable to prompt change in the design of services in the acute sector, would try and keep patients in primary care settings, thus using new resources to duplicate facilities already available in acute centres. These combined with the cult of personal accountability and the resulting inability to convey any bad news upwards, would lead, they may have suggested, to serious financial problems once those short term fixes and fudges could deliver no more 'savings' and the additional costs of duplicate provision and of meeting and monitoring targets kicked in.

How might they view the suggestions that increasing the 'power' of 'strategic commissioners' is what is needed? Perhaps they would suggest that any increase in pressure on acute sector managers would mean they now find themselves between a rock ('powerful' and intransigent

¹ In *Managing the Myths of Health Care*, Feb 2006, Henry Mintzberg distinguishes between managerialism and MANAGERIALISM. The latter being the more *in your face* form.

commissioners') and a hard place (clinicians who see no reason to change), and that the increasing pressure will lead to an ever more rapid turnover of those managers and their teams.

What is it we are trying to achieve?

Philosopher / development economist Amartya Sen² encourages us to focus on what it is we are trying to achieve rather than on economic processes that are supposed to take us there. So perhaps it is worth being clear just what it is we are trying to achieve.

If the problem is that we have professionals, of sufficiently high status to be able to skew local decisions in their favour, paying insufficient attention to the needs of the tax payer and the population as a whole in their concern to be able to offer ever better services for their own patients, then what we want to achieve is good quality decision making informed by clinical perspectives but not inappropriately influenced by issues of status. The solution is likely to involve high status professionals reflecting proactively on their own practices and the design of services in which they are involved³, and taking a collective responsibility for the stewardship of the organisations of which they are a part⁴, and if that is what we are trying to achieve we should give it the explicit attention it deserves.

If we do so, if we think about how individuals with sufficiently high status to be able to recruit the media and the public to their cause, we can see they will be able to resist any pressure from managers or politicians to change. We can imagine too that exposing them to a centrally generated specification of best practice will influence some but is likely to antagonise just as many. And we can imagine that increasing either kind of pressure will severely reduce any enthusiasm they may have had for sharing a responsibility for the organisation as a whole. So, if pressure from managers or from centrally recruited peers will not work what are the influences that will prompt high status individuals to design or accept change? There are several (our sociology or political science observers may suggest) and they all involve allowing⁵ individuals to see for themselves that change is both necessary and possible.

1. Information

Information about how their practice and their service compares with that of others, or with their own practice/service over time. The information needs to be credible (based on robust and

² See *Development as Freedom* Amartya Sen, Oxford University Press 1999

³ Making good use of resources will always involve a consideration of whether savings can be made in some areas to allow investments in others. When savings have to be made there are four major means of doing so:

- cuts,
- rationalisation of services,
- redesign of services, and
- reflection by practitioners on individual practice.

In a healthy system all four are used, starting with the last – reflection by individual practitioners. In organisations with a connected hierarchy in which the front line broadly accept the authority of their managers, in which there are organisationally sanctioned incentives for individuals and teams to reflect and redesign, this is what happens. However where the hierarchy is disconnected (see Best G, *Managerial Hierarchies and Health Care Reform: A Precautionary Tale for the Millennium*, an OD Partnerships Network paper), and especially where high status groups can operate with considerable autonomy, there is a tendency instead to start at the top and not to reach the bottom.

⁴ There is some evidence in the States of clinicians being actively involved in the stewardship of some of what are regarded as the best hospitals and hospital systems (e.g. Kaiser Permanente, Mayo Clinics, Massachusetts General among others).

⁵ 'encouraging' may be as useful a word here as allowing, but only if it does not stray into 'requiring'.

relevant data) and presented in a way that is meaningful to those concerned (analysed in terms of activity clusters at the right level of detail/aggregation, for example).

Interestingly, one centrally driven initiative in the late '80s did focus on information. Work undertaken at six Resource Management Initiative pilot sites brought clinicians and managers together as they devised means of implementing clinical information systems from which information could be drawn for clinical (delivery and audit) and managerial (resource deployment and organisational performance monitoring) purposes. Unfortunately it was overtaken by the advent of the internal market, and the formal evaluation, using the dominant economic lens again, found it had not improved clinical or financial outcomes, despite the major impact it had had on clinical-managerial relationships. A sociology lens might have indicated that these just hadn't had time to yield tangible results, but that they were well on the way to doing so. Now that an interest in information has re-surfaced, this time energised from a patient perspective (what do patients want to know about outcomes) and by the needs of boards of foundation trusts to take responsibility for the fortunes of their organisation, some useful work has been done identifying the kind of information needed for effective decisions about deploying resources and monitoring sub-organisational performance. If this is to yield genuine improvements in efficiency and effectiveness it will need to reinvent or build on the approaches of some of the RMI sites. This will mean taking a totally different approach from the national IT project now called Connecting for health which has chosen to focus entirely on lowest common denominator data for clinical delivery, ignoring the opportunity to help clinicians (and managers) understand and control costs, as well as incur and monitor them.

2. Peer example.

While pressure from peers can be resisted, opportunities to discover that the practice of peers and the design of their services is different, and to explore the implications of those differences, can lead to very constructive reflections on both of these. Engaging in this process of discovery is likely, however, to be resisted unless there is one of the two following features:

3. Managers who genuinely care about the care that is being offered and who want to help clinicians improve that care⁶.

When managers care first about care and only then about their organisations (as the best means of offering good care), and demonstrate that commitment by taking an active interest and by responding creatively and quickly to clinical suggestions about service improvements, then their credibility will allow them to draw attention to some of the opportunities described above. This requirement for immediate and practical support for changes specified by from line staff is one of the reasons the Lean Thinking approach can be so successful. This enthusiasm for care cannot deter them from stating clearly financial and other realities, and they must demonstrate their competence at dealing with managerial processes, but they must be driven first by concern for effective care, and definitely not by a primary concern for balancing books which allows care to suffer in order to achieve it.

4. Thought leaders who are from a high status group who don't impose their own prescriptions for action but who hold high expectations of the performance of others.

Similarly the credibility of these individuals allows them to provide the challenges that encourage mature reflection rather than defensive resistance.

5. Organisational stewardship.

Where high status clinicians are allowed and encouraged to form some kind of 'clinical senate' whose brief is to shape the organisation's strategy, to ensure the consultant body understands

⁶ See Iles V, Really Managing Health Care 2nd edition 2005

the internal and external pressures that make it the best way forward, and to challenge behaviours and practices that are not consistent with that direction, then results can be impressive⁷.

6. *First hand stories*⁸ from patients and from other HCPs .

While second or third hand stories and written complaints can be dismissed and the motives of their authors impugned, first hand stories are a different matter. These can reflect the experiences of patients or those of other HCPs. It is often one of the most valuable outcomes of discussions about care pathways – as long as the highest status people are in the room to hear the stories, and often they are not; and as long as the discussions are well facilitated so they consist of personal narratives (this is what I experienced) rather than accusation and blame (this is what you did).

6. *And especially when these become embedded into the culture of the organisation.*

We can imagine that while one or two of these methods are helpful, if they became embedded in ‘the way we do things round here’ their impact would be very much greater.

It is interesting to reflect on the behaviour of some of the more successful clinical networks in light of these headings, in that they collect and use information specified by their members, expose members to peer example, are coordinated by people who care about the services offered to patients, can often include thought leaders who expect the best of their colleagues, do collect and use first hand patient experiences, and the whole enterprise could be seen as exercising a form of stewardship.

Can strategic commissioning from foundation trusts take us there?

If we look through the economic, or MANAGERIALIST lens then we will encourage strategic commissioners to:

- draft legally binding contracts skilfully, using knowledge gained from poachers turned gamekeepers (people with a good knowledge of acute sector provision),
- build in penalty clauses for underperformance on a number of dimensions,
- monitor that performance carefully and exercise their power to enforce the contract provisions⁹.

Organisations will then **‘have’** to deliver quality, efficiency, effectiveness ...etc

Using instead a sociology or political science lens we might say, ‘yes, but **how** will the organisations do this?’ If we want clinicians reflecting on their own practice and on the design of the services in which they are involved, then we should encourage the strategic commissioners to focus explicitly on this. Wise commissioners have always seen the contract as the end of a process rather than the beginning (good ones have lived this out, poor ones have used this language as an excuse for tardy agreements), and we should encourage this if we are to achieve real change and not just managerial turnover.

⁷ while there is no single ‘right way’ to run clinical senates there is much valuable experience captured in Best G, Some Notes on Involving Clinicians in Health Systems Governance, an OD Partnerships Network paper.

⁸ See Bate P

⁹ The cynic may also add:

- contribute to the profits of the large consulting firms such as Mckinsey and KPMG.

This author is not as cynical as this, but does wonder at the increasingly close relationship developing between government, in general, and the Regulator of FTs (Monitor), in particular, and these firms.

If commissioners chose to see their role as working alongside acute sector colleagues to encourage high status clinicians to work constructively on service redesign in pursuit of improved quality and reduced cost, they could play a helpful, indeed vital role. They hold much of the information that is needed if managers and clinicians are to understand the dynamics of their performance. They can help identify comparable services that are better designed. They can encourage managers to care about care, and so on. If they can see their role as helping rather than as fighting there is a chance this will not be a hugely expensive 'industry' of form filling and bean counting, but a genuinely helpful means of energising their acute sector colleagues to address the core issue.

Are there other answers?

How it is that something so immediately and pervasively apparent to those working within health care as status and its impact on behaviours, decisions and working practices, is not discussed more openly? Somehow the fact that status does not equate or correlate with moral worth, likeability, or even with importance to the health care task, has allowed a political correctness to dictate that we never distinguish in our talk (or in our training or OD initiatives) between the status of different health care professions. There is a mantra of 'interprofessional this' or 'multi professional that', that is somehow trying to deny the existence of status differences, and in doing so to squeeze them out. This will fail miserably (and expensively) and we need to learn as much as we can from this failure.

There is another reason, too, for explicit consideration of status within the professions and that is that the nature of professions is changing and in ways that many professionals find threatening. Now that the internet means that professional knowledge bases are no longer exclusive, the needs of individual patients are increasingly complex¹⁰, and evidence based care is changing the degree of autonomy over clinical decision making, different clusters of skills may be needed, and the status accorded to those skill clusters may also be different. Whenever individuals or groups are required to give up something they value we can expect resistance and we will need to engage many interested parties in far greater debate about the nature and implications of these changes if these changes to professions are not to be disruptive and to sacrifice good patient care.

So we can see that we need to have discussions about at least two aspects of status: how to influence high status professionals to act in the best interests of patients and tax payers; and how professional boundaries and status may change and how any adverse implications of these changes for patients and tax payers can be minimised. We can also see that we are disinclined to do so (which is itself a manifestation of that status). So we need not only to prompt a discussion about these issues, but ensure some means of energising it.

Who would be the most relevant contributors, and could any of these provide the necessary energy to prompt and maintain the dialogue? The BMA would be well placed to do contribute to such a debate but would need a transformation of attitude on a Pauline scale if they were to lead it. Similarly the DH and the NHS Confederation are both dominated by a managerialist paradigm¹¹ that needs to be party to the discussion but not in the forefront. This debate should

¹⁰ Work in progress by Maria Duggan on viewing Personality Disorder as a set of complex needs and therefore amenable to complexity theory. Another way of thinking about this is to use Russell Ackoff's distinction between puzzles, problems and messes, and to suggest that health care professionals are increasingly dealing with messes rather than the puzzles and problems for which they have been trained.

¹¹ This is not a condemnation of either, arguably this mindset has led to the DH outperforming other government depts, and the Confed is a membership organisation whose members are managers and which must keep close to the DH.

involve sociologists, political scientists, systems scientists, philosophers and information scientists, perhaps experts in community or even overseas development, people who understand the dynamics of professions and professionalised organisations as well as the practice and potential of health care.

For this to happen we will need to accept the need for a new way of conceptualising our problems with the health care system. In short we need to find a way of applying to our overall health system the principles taught us by our organisational learning colleagues¹²: we must fix what is going wrong (single loop learning, e.g. reducing financial overspends or ensuring care meets guidelines), we must check out the systems that have led to it going wrong (double loop learning, e.g. the system of personal accountability for achieving targets) and we must challenge the paradigm within which we were thinking that prevented us from seeing the faults of those systems (deutero or triple loop learning). If we take the third learning loop seriously then we may consider there are two sets of assumptions we are making that need examination.

We could consider, for example, that even if the cumbersome market apparatus is necessary, it is certainly not sufficient; and that we must find ways of paying explicit attention to means of persuading our highest status clinicians to take on stewardship roles for the wider system and not only their own services. In order to do this we need to pay attention to the dynamics within and between professions, and between professions and society. We need to understand how professions see professionalism and consider the nature of professionalism that yields the greatest benefits for professionals, patients, communities and tax payers. Currently this is a debate left almost entirely to educationalists within the professions and it suffers from a lack of the kind of challenge that could be made by the groups listed above.

The potential benefits arising from such a debate are very great. It is conceivable that we find that we are able to dismantle the contracting process and liberate the billions consumed by it, so that we could spend those on *productive* aspects of the system, for example on excellent: health needs assessment, information for both clinicians and managers that arises from the interactions between clinicians and patients, mechanisms for peer example, and first hand stories, development for managers, to enable them to care about care first and organisations second, identification and support for thought leaders within the professions, on redesign and on CARE.

We may not find this, we may find that contracts are the best way of providing the energy that ensures practice is constantly reviewed and improved, but we would also know that this has to be twinned with processes specifically aimed at increasing organisational stewardship.

As we challenged our assumptions we might also recognise as fundamentally flawed the notion that any management consultant or policy advice team is better at devising structures and processes for the complex, dynamic interdependent set of systems, that together comprise our national health care, than are the people working within them. It is not Roy Griffiths' fault that his prescription took the system as a whole in the wrong direction for 20 years, but we must make sure we never again allow one person's view to prevail. We must find ways of allowing locally relevant solutions to develop and flourish, devised, owned and implemented by local teams of clinicians and managers, held to account only for their outcomes and not for implementing a centrally prescribed set of processes.

¹² See Argyris C and Schon D Overcoming Organisational Defenses, or for a succinct summary the third case study in Iles V and Cranfield S Developing Change Management Skills.

Work in progress
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