

Liberating the NHS or trapping doctors?

The effects of NHS reform on today and tomorrow

INTRODUCTION

The coalition government recently revealed the ambitious task of 'liberating the NHS', a goal identified as the widest reforming change that the NHS has seen since its inception in 1948.¹ The White Paper² champions ideological aims to empower doctors while placing patients at the centre of their own management decisions, adopting the maxim 'no decision about me, without me'.² While such proposals have been optimistically publicised, on the surface heralding empowerment for both doctors and patients and rightly so, they nevertheless raise a pertinent question: is the motive to actually empower doctors or is it simply a shift of responsibility? At a time when there is financial pressure to cut costs of public services, many might cynically think that this is a way of government conveniently devolving the responsibility for 'cuts' which are soon to come; however, Mr Lansley did suggest some of the proposals in the White Paper before the global economic downturn.

DOCTORS, PATIENTS, AND TRAINEES: EMPOWERING AUTONOMY

For GPs especially, the reform entails an increasingly managerial role in addition to their clinical duties. 'GP consortiums' will eventually control up to 80% of the NHS budget by 2013 when local primary care trusts (PCTs) are set to be abolished.^{2,3} The final outcome is intended to be a GP-led, bottom-up system, providing GPs with greater independence arguably improving their ability to provide patient care and optimise use of resources within their assigned communities. Of course, it may be challenging to commission services on unfavourable terms, and whether GPs will better understand the limits of what can be provided is still unanswered. Consortiums that work well to meet targets will be rewarded with lucrative incentives whereas struggling ones are unlikely to be bailed out, nevertheless special measures are supposed to be implemented by the NHS

Commissioning Board in case of any over-spending. A separate but vital issue is whether typical GPs, let alone current trainees, have been or are being educated appropriately to manage huge financial responsibilities; and will the new expectations in relation to GP commissioning alter career decisions for trainees?

As for hospitals, the proposed aims will introduce market forces and promote growth of the private sector with increased outsourcing to cost-beneficial businesses. Furthermore, by 2014 all hospitals will be given a Foundation Trust status which will offer the choice to leave public ownership while still providing public services as seen fit. Whether this privatisation will be of benefit to the NHS is highly contested by staff⁴ and remains to be determined;^{5,6} yet, hospitals that are within competitive markets (which are governed by patient choice) may save £115 million without losing staff.⁷

For patients, the reform entails greater choice and autonomy, with the aim of improved participation and responsibility in their healthcare pathway. Patients may register with any GP and from 2011 will be able to choose between consultant-led teams for elective care, an extension of the current 'choose and book' protocol which was introduced during the last Labour administration. Greater patient involvement is certainly to be encouraged and is taught as a major principle within British medical curricula, but much significance is already given to providing optimal, evidence-based, and holistic patient-centred care management. Furthermore, introducing league tables to compare success rates between healthcare practices may eventually skew waiting lists (without patients necessarily understanding complexities inherent in the data upon which tables are based) at popular sites, and lead to closing down under-performing trusts without adequate contingency plans. It is imperative to maintain both patient choice and equality which are, in fact, often competing factors.⁶

PARADIGM SHIFT IN BRITISH HEALTH REFORM OR PASSING THE BUCK?

Surrounding the bold aims of the new reform are a number of doubts. Chief among them is the inescapable feeling that reform is always more politically motivated than it is aimed at improving life for end-users. Prior to the general election of 2002, the Conservatives had pledged a social insurance scheme to fund the NHS in competition to Labour's plans to raise spending through National Insurance contributions.⁸ They were unsuccessful in convincing the public but 8 years on, David Cameron's leadership of the Conservatives has heralded a new image for the party in which the old ideals of a fully privatised NHS have been dropped in favour of a more centrist political position.

However, for those worried that the new White Paper is merely a 'wolf in sheep's clothing' (for privatisation), a recent editorial in *The Lancet* will do little to calm their fears.⁹ The journal was passed a document by the Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust that set out proposed cuts to services. Tellingly, the authors of the report admit in several places that significant negative effects are a likely result. Given the economic situation, this report on cuts is probably only the beginning of a testing time.

Although the White Paper argues to cut bureaucracy and to '[free up] doctors and nurses to do what they do best — take care of their patients',¹⁰ in actual fact they will be decentralising administrative work to GPs, which may take time away from clinical work. Novel training programmes are clearly required within curricula to nurture leadership, managerial, and fiscal skills in doctors such as the Medical Leadership Competency Framework¹¹ especially with the transfer of £80 billion of responsibility to GPs.² However, whether this is possible in a background of meeting governmental targets and avoiding malpractice lawsuits due to further extra-curricular responsibilities is questionable. Possibilities for such training

include postgraduate degrees in health management¹² and clinical leadership fellowships from the Department of Health.¹³ Otherwise, if GPs seek expertise from administrative staff (such as former PCT managers), will the benefits of engaging clinicians be diluted and will the decentralised administration be any more efficient than the current 'top-down' style of commissioning?

While many doctors feel that there are capable individuals working for PCTs but doing unnecessary jobs, such doctors may not feel that such radical reform is the best way to tackle this. 'Change fatigue' is rife and the cost of change for the sake of change can be very heavy. The untested reform, expected to cost an estimated £1.7 billion,¹⁴ will place strain on an already burdened NHS, at a time when the economy desperately needs stability and austerity. Given that the NHS is comprised of over 1.4 million employees, such significant changes will almost certainly detract from efficiency,⁴ stunt cohesion and focus, and undermine improvements achieved over the past decade¹⁵⁻¹⁷ all in the hope of saving £20 billion after full implementation.² Yet, the national reform may be able to foster a healthy relationship between primary and referred healthcare systems by inviting hospital doctors onto panels in charge of redesigning the primary healthcare service¹⁸ which is undoubtedly one of Britain's proudest accomplishments. Furthermore, open meetings are encouraged to keep the public updated, gain its trust and integrate reasonable and plausible demands within the NHS.

PASSING ON THE BATON: POTENTIAL KNOCK-ON EFFECTS ON TRAINING

It is not only GPs who may have less time to spend with their trainees under the proposals. Many speculate that increased market forces could shift the focus in hospitals further towards efficient service provision at the expense of training opportunities. There are already studies

suggesting that, in some cases, training in Independent Sector Treatment Centres (ISTCs) is inadequate.¹⁹ Postgraduate training is still struggling to adjust to the challenges posed by the European Working Time Directive (including within military practice²⁰) and further threats from pseudo-privatisation could derail current efforts to maintain effective junior doctor teaching.

In any case, teaching is not an optional activity; it is fundamental to ensuring continuity of proficient, competent, service provision and should be valued as a crucial long-term investment. Sacrificing it for short-term efficiency targets and political point scoring would be a grave error. Consequently, it will be more important than ever before to ensure that training time is ring-fenced wherever possible and that the situation is closely monitored by all respective Royal Colleges and recognised institutions.

CONCLUSION

The proposed NHS reform will change health care and redefine the role of doctors in the UK. The result will hopefully be a patient-centred NHS light on bureaucracy with empowered healthcare professionals. These are matched by new opportunities for doctors, further training, and the possibility of improving the distribution of NHS resources according to medical need rather than traditionally depending on politicians or managers. Nevertheless, liberation implies freedom from a tyrant regime, in which case what does liberation mean? Is it just a hollow but pleasant-sounding term like 'modernisation'? Have doctors finally won the struggle for power or are we simply caught in another politician's web?

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REFERENCES

1. Ham C. The coalition government's plans for the NHS in England. *BMJ* 2010; **341**: c3790.
2. Department of Health. Secretary of State for Health. Equity and excellence: liberating the NHS. London: 2010.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digital_assets/@dh/@en/@ps/documents/digitalasset/dh_117352.pdf (accessed 6 Oct 2010).

3. Roland M. What will the white paper mean for GPs? *BMJ* 2010; **341**: c3985.
4. Wallace A, Taylor-Gooby P. New labour and reform of the English NHS: user views and attitudes. *Health Expect* 2010; **13**: 208-217.
5. Maynard A. How will the Tories reform the NHS? *J R Soc Med* 2010; **103**: 168-72.
6. Nagendran M, Budhdeo S, Maruthappu M, Sugand K. Should the NHS be privatized? Annual varsity medical debate - London, 22 Jan 2010. *Philos Ethics Humanit Med* 2010; **5**: 7.
7. Giving hospitals a competitive edge helps patients and saves cash. *The Times* 2010, **30 July**: <http://www.thetimes.co.uk/tto/business/industries/publicsector/article2665787.ece> (accessed 18 Sept 2010).
8. Eaton L. Labour and Conservatives draw up battle lines on NHS. *BMJ* 2002; **324**: 935.
9. Mr Lansley: please tell us the truth. *Lancet* 2010; **376**: 205. [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(10\)61114-2/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)61114-2/fulltext) (accessed 6 Oct 2010).
10. Smith R. NHS reforms will cost £3bn and will not work: academic. *The Telegraph* 2010, **16 July**: <http://www.telegraph.co.uk/health/healthnews/7894611/bmj-editorial.html> (accessed 6 Oct 2010).
11. NHS Institute for Innovation and Improvement. Medical Leadership Competency Framework. http://www.institute.nhs.uk/assessment_tool/general/medical_leadership_competency_framework_-_homepage.html (accessed 6 Oct 2010).
12. Imperial College London. Imperial College Business School. MSc International Health Management. <http://www3.imperial.ac.uk/business-school/programmes/msc-health-management> (accessed 6 Oct 2010).
13. Department of Health. Clinical Leadership Fellowship Programme. Department of Health: London, 2010. http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_109166 (accessed 6 Oct 2010).
14. Trigg N. NHS sets £1.7bn aside for reform. *BBC News Health* 2010, **16 July**: <http://www.bbc.co.uk/news/health-10647910> (accessed 6 Oct 2010).
15. Fulop N, Protosaltis G, King A, et al. Changing organisations: a study of the context and processes of mergers of health care providers in England. *Social Sci Med* 2005; **60**: 119-30.
16. Walshe K. Reorganisation of the NHS in England. *BMJ* 2010; **341**: c3843.
17. McKinley W, Scherer AG. Some unanticipated consequences of organisational restructuring. *Acad Manage Rev* 2000; **25**: 735-52.
18. Practical Commissioning. GPC publishes blueprint for GP commissioning. *Pulse Today* 2010, **16 Sept**: <http://www.pulsetoday.co.uk/story.asp?sectioncode=40&storycode=4127101> (accessed 18 Sept 2010).
19. Clamp JA, Baiju D Sr, Copas DP, et al. Do Independent Sector Treatment Centres (ISTC) impact on specialist registrar training in primary hip and knee arthroplasty? *Ann R Coll Surg Engl* 2008; **90**: 492-496.
20. Sugand K, Hills AJ, Agha R. Military medicine and European Working Time Directive - can you still 'BE THE BEST'? *QJM* 2010 Jun 9. doi: 10.1093/qjmed/hcq092.

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