Restoring a sense of balance to NHS reform

INTRODUCTION

While the recent receipt of royal assent for the 2012 Health and Social Care Act in England represents the end of a long process for policy makers, its ramifications will reverberate around the NHS in England for years to come. The Bill's passage through parliament was a messy business, one that could form a classic 'how not to do it' text for tomorrow's students of politics. But the reality is that health reform always feels momentous and is usually an imperfect and painful process. The NHS market reforms in the 1990s and the managerial reforms of the 1980s were probably more radical than the current ones. The vitriolic opposition to the Obama health reforms in the US¹ make the negotiations over the Health Bill look like child's play. And the introduction of competition over the last two decades in Sweden has been much more countercultural than anything ever seen in UK.²

People care about health, and that is why reform is associated with passionate arguments based on deeply held values, selective use of evidence, and not a little Machiavellianism on both sides. Reform leaves bruised egos and damaged relationships between those involved, and a mixture of bewilderment, cynicism, and sometimes a sense of guilt from those who have, for whatever reason, not taken to the streets or taken up their pens in opposition.

So, as tempers calm and those who work in the NHS do what they always do — try, to the best of their ability, to make the system work — now is a good time to stand back and take a dispassionate view of the policy processes underpinning health system reform.

WHAT DOES HEALTH REFORM AIM TO ACHIEVE?

This is not as straightforward a question as it might appear. Most obviously, reform aims to address known deficiencies in the established system. The problem is that there is often little consensus about the nature and scale of the deficiencies. The evidence tells us that the NHS has improved dramatically over the last 15 years.³ In addition, it tells us that the NHS is one of the highest performing health systems in the world.⁴ But there is also irrefutable evidence that the NHS still has major problems, for example with the lack of humanity and

kindness with which many patients are treated⁵ and with unwarranted variation in areas such as limb amputation for patients with diabetes.⁶ All of these positions can and have been evidenced and the lack of a common position lies at the root of arguments about the need for and nature of reform.

In addition to solving immediate problems, there are at least three other reasons for reform. The first is to 'future proof' the health system, to ensure that it is able to respond to the demographic, social, economic, and technological challenges that lie ahead. This can be a difficult argument because prediction is hard (particularly about the future, as Niels Bohr reminded us) and people are inclined to discount future benefit in favour of the status quo.

Second, reform sometimes simply aims to shake up the system in order to achieve change at a faster pace than would happen without intervention from government. Many commentators have suggested that Andrew Lansley, the Secretary of State for Health in England, could have achieved his aims by working within current NHS structures.⁷ But he knew just how entrenched attitudes and behaviour are and how great the voltage drop is between policy intent and outcome on the ground in the absence of 'shock and awe' policy tactics. It is all very well, he might argue, to say that some parts of the country were delivering clinically-led commissioning before the reforms but a small number of enthusiasts won't shift the vested interests of providers, the power position of commissioning managers, or the lack of interest of the majority of stakeholders.

Third, it is clear that health reforms are often simply one small part of a wider intent, to change the nature of our society by encouraging, for example, a smaller state, a more mixed economy, or a stronger public voice. In this situation, the health service

sometimes becomes a pawn, perhaps collateral damage, in a bigger game.

WHAT FACTORS INFLUENCE THE NATURE OF REFORM?

If we examine any reform process we will see multiple factors at play. The most important of these are ideology, personal experience, political pragmatism, and scientific evidence.

Ideology will always be important. Socialism established the NHS, capitalism first introduced the market reforms, centralism drove the performance management reforms of the early years of the last labour government and localism, the current reforms of the coalition government. Ideology is usually the most powerful of politically-initiated reform drivers and is inevitably the most polarising.

The personal experience of the power players is also important. Nye Bevan's exposure to poverty and hardship in the Welsh valleys in the 1930s strongly influenced his commitment to a nationalised health system, as he described powerfully in his biography *In Place Of Fear*.⁸ But experience can play out in more mundane ways. Members of Parliament who rarely see a GP and whose main exposure is through complaints from their constituents are unlikely to be sympathetic to the current model of general practice. There is good evidence that our personal experiences and those of people around us are highly influential in forming our opinions,⁹ however biased such experiences can be.

While ideology and experience influence the planning process, political pragmatism is a strong determinant of what happens in practice. The post-war Labour government's willingness to 'stuff consultant's mouths with gold' in order to buy their support is well recorded.¹⁰ GPs were unlikely to have bought into the political micromanagement of their

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behaviour if the government had not been so willing to compromise with the BMA around the nature of the 2004 GMS contract. And Andrew Lansley's decision to set up a 'listening exercise' was less about a new found receptivity to the views of stakeholders than a change of tactic to defuse the mounting criticisms of his reforms. Pragmatism is good because it gets things done but it can be problematic when compromise favours those with the most power and influence.

Last, and too often least, comes scientific evidence: a way of knowing which, unlike ideology, experience, and pragmatism, aims to produce generalisable knowledge through rigorous and systematic inquiry. Although it is the most rational way of knowing, this does not mean that utilising scientific evidence is straightforward. Paraphrasing Andrew Lang, the 19th century Scottish poet, we are all guilty of using evidence as a drunk uses a lamp post, more for support than illumination. Policy makers and politicians (of professional as well as a party political nature) are especially guilty of this, particularly in relation to the science underpinning how health care is organised and delivered. This science — the science of improvement or implementation — is different from the biomedical and clinical sciences that have become deeply embedded within the psyche of health professionals in the form of evidence-based practice. Improvement science is newer and therefore less well developed and both the nature of the questions asked and the methods used, based more on the social than the physical sciences, are less amenable to producing definitive answers. Despite this, improvement science has produced a useful evidence base to guide the organisation and delivery of health care, albeit one that was largely ignored or misrepresented by most parties in the heated arguments about the latest health reforms.

HOW MIGHT EVIDENCE HAVE INFORMED THE REFORMS?

If there had been a commitment to utilising

the science of improvement then many of the assertions of both advocates and opponents of the reforms would have been tempered. Two examples illustrate this point. First, take the evidence underpinning the impact of competition in the health sector. A balanced appraisal of a growing body of international evidence shows that economic competition can be an effective lever for change in some circumstances. But in other situations it has almost no impact and is often associated with significant unintended consequences.¹¹ In contrast, research into competition based on professional reputation, often through the publication of comparative performance data, demonstrates that this is an effective intervention most of the time,¹² and research provides useful insights into how the competitive instincts of health professionals can be utilised without stimulating what have been described as 'gaming' behaviours.¹³ Overall, an evidence-oriented approach to reform would have focused more on reputational than economic competition and would have positioned the latter as a useful lever for change at the margins, albeit one that should be used cautiously.

The second example relates to the impact of organisational restructuring and the implementation of large scale change management programmes. Research¹⁴ suggests that such changes can sometimes be beneficial, although they are often a short-term distraction and it usually takes several years for any benefits to be realised. In a significant minority of cases such changes can cause damage. It is hard to see how the removal of several layers of NHS management in the current reforms (and their replacement with several new layers) will be anything but a distraction as the NHS struggles with financial challenges. Overall, an evidence-oriented approach to reform would have minimised structural change at the current time, favouring other approaches (such as using incentives and educational interventions) to stimulate behaviour change.

CONCLUSION

The roller coaster ride that has resulted in

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the 2012 Health and Social Care Act reminds us how important it is to improve the ways in which health system reform is designed and implemented. We need to understand why reform happens and the factors that influence its intent and form. Ideological, experiential, and pragmatic drivers for change should not be discounted as political interference. They are important and need to be understood and influenced whenever possible to achieve the best outcomes for patients. But the greatest potential for improving health reform lies in the better use of evidence to inform policy decisions and this requires a commitment to the development and use of the science of improvement on the part of all stakeholders, from policy makers to service managers, front line clinicians and patients. Doing so will help to restore a sense of balance to health reform which will only benefit those who use health services.

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Provenance

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