Will the age of austerity save the NHS?

I have always been a passionate supporter of the NHS and initially viewed the Nicholson challenge as a threat to the future of the NHS; now though I wonder if it may actually save the NHS.

Among the many good things the last government did for the NHS there were changes that have significantly increased costs without improving quality of service. Agenda for change, the working time directive, the notion that consultant doctors were getting out of all hours of improved quality of life for staff, but have not improved health outcomes for patients. Also, the migration of A&E and one stop, two step services has not improved outcomes has also reduced productivity. Innovations in patient services, such as walk in centres, NHS Direct and Cara centres, again driven more by wants than needs, have improved access without improvements in health outcomes. This has come at a time of permanently unproven advances in quality of life and life expectancy, with the elderly population in some areas growing by 30% over the past 10 years. A rapidly increasing elderly population with falling productivity will make current NHS provision unaffordable within a generation.

With the population growing and health cost inflation exceeding GDP growth even pre-2008 levels of funding will soon be overtaken by increasing strain on OOH care: lowering/eliminating nurse appointments and not competition for the majority of the population.

The recent paper by Patterson et al reports the encouraging and considerable predictive validity of MCQ (CPS: clinical problem solving) and situational judgement test (SJT) selection tests for performance on the two MRCGP formal examination components. The MCQ and the SJT correlate with the Applied Knowledge Test (AKT) at 0.85 and 0.82 respectively. Range-correction of statistically provided in the paper, together the two selection tests can be seen to predict 74-75% of AKT variance. The two tests also correlate with the old-style Clinical Skills Assessment (CSA: 0.53, 0.57 respectively; range-corrected. Together these two correlate with an 88% of CSA Score variance. But the subsequent Selection Centre (SC), then a three stage OSTE and correlating with the CSA at 0.41 range-corrected, is reported as only explaining an additional 2% of CSA score variance.

Given that a set of computer-delivered multi-choice tests will cost £100-200 per candidate and that the true cost of a selection centre will be at least £1000, the latter seems to provide relatively very poor value, especially with about 5000 candidates being shortlisted for selection in 2012. Perhaps the 45 million plus could be better used in supporting poorly performing trainees.

Also, all of us who are responsible for devising OSTE assessments would find it useful to learn how one with three stations, single marked, can be devised such that its reliability (correlation between each station does not longer similar assessments give far lower reliability estimates) for example, MRCGP CSA (r=0.77) and IMRCs Part B (8 station subscales 0.68-0.72 and 10 station subscales 0.76-0.78).

Richard Wakeford,
Higgs Hall, University of Cambridge,
Cambridge.
E-mail: rsw25@cam.ac.uk

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