NHSCA

EDITORIAL March 2010

The Consultant and the NHS

The NHS Consultants' Association was founded in the mid-1970s "by consultants with a strong commitment to the NHS and its founding principles". There were then about 5,000 full time, 6,000 part-time (and 1,400 'honoraries', virtually all of these, including me, clinical academics). The consultant role has changed quite dramatically, both quantitatively and qualitatively (and financially), since then as have relationships between professionals and, particularly, with management. Average annual pay has risen from about £9,000/ year in 1976 to almost £110.000/ year in 2005/6!

The raison d'être of the Association has become even more glaringly apparent. Concerns about the future of the NHS have even made some members question the appropriateness of a purely consultants' association at a time when the 'founding principles' themselves seem to be threatened by the very establishment which formulated them. It is with some aspects of the role of the NHS consultant that this editorial treats. It is less than comprehensive and leaves several important areas untouched. No doubt deficiencies, errors and misinterpretations will be dealt with by 'readers' letters', some perhaps for later publication.

Background

Becoming an NHS consultant had to be one of the landmark events in the life of a UK hospital doctor. As well as being a recognition of having achieved a competence in a chosen discipline, it symbolised the assumption of a certain independence of status, security of employment tenure and a comfortable level of assured income. It also signalled the acceptance of professional responsibilities, some explicit but many hardly even verbalised. Consultant status usually meant the assumption of leadership of a team of junior doctors, nurses, technical and secretarial staff and a share in the governance and policy-making of the institution. It was the culmination of many years of preparation and training and the high point of the ambition of the great majority. It meant a job for life or at least until statutory retirement age with the prospect of a comfortable final-income based retirement pension.

Early Contacts

For most students of medicine, exposure to the consultant ethos still usually starts with educational assignment to the clinical disciplines in the wards and out patient clinics of the teaching hospital. These key and highly impressionable years have evolved a great deal over the decades. However, it is still within the memory of many of their first meetings with the teaching hospital 'honoraries' whose reputations as leaders of the profession rested in large part on their unpaid services to the working class sick who relied on the voluntary hospitals and the Lady Almoner for much of their care and welfare.

The Consultant Image

The mythology of the teaching hospital consultants, many of them seemingly larger than life and competing in eccentricity, has been well preserved for example by Bernard Shaw in his 1906 classic The Doctor's Dilemma, in Sir Colenso Ridgeon said to have been modelled on Sir Almroth Wright and the nuciformectomist surgeon, Cutler Walpole on Sir William Arbuthnot-Lane. The memorable stereotype surgeon was created, albeit fancifully caricatured, by James Robertson Justice as Sir Lancelot Spratt in the 1954 film of Richard Gordon's book, Doctor in the House. There was little if any contact for the student with the body of paid consultants who worked on a sessional and sometimes fulltime basis in the local authority supported Municipal Hospitals where the great bulk of the real work of medicine

was done. Julian Tudor Hart scathingly describes this generation of honoraries in his book A New Kind of Doctor which also conveys the contempt which many of them expressed for their colleagues in general practice, setting the scene for lifelong attitudes for many, handed on by some to this day.

The Consultant Role

In considering the title 'consultant' in relation to the NHS, one is struck by its heterogeneity. The term covers a wide variety of disciplines not all of them clinical, some not even medical. Horror stories of the millions spent on often self-styled management consultants purporting to instruct us how to manage our hospitals and practices, largely based upon American practice where management aims at optimising income and minimising financial risk. Consultants will now teach us NHS Leadership – again doubtless with a financially enriching transatlantic flavour.

Within the NHS family we now have nurse consultants, consultant pharmacists, consultant physiotherapists and so on. The traditional view was that the medical consultant was the 'aristocracy' of the profession. It is to the consultant that the generalist turns when the most mature judgement is required. The 1948 advent of the NHS itself contributed substantially to consultant status, due in no little measure to the support the new legislation received from consultants in the face of the bitter opposition from the GPs, whipped up by the BMA.

Apart from exercising the central function of specialist clinician, the consultant can be viewed in many other lights e.g. as a teacher, a manager, a researcher, a planner and policy maker, an entrepreneur, a role model, a patient advocate, by some as a god and by others, a devil.

The Consultant Body – Size and Trends

The most recent review of consultants in the English NHS, in the setting of the total NHS workforce, was published in March 2009. Table 1 details numbers employed in the various major employment categories, covering the period 1998 to 2008 and showing rates of growth, averaging the percentage annual increase over the whole ten years and over the final year covered to give some idea of the most recent changing growth rates.

NHS Workforce for England 1998 - 2008
(Info Ctre Hlth & Soc Care, Mar 2009)

	1998	2008	Annl % Inc	07/08 Inc
Total NHS Workforce	1,071,562	1,368,693	2.50%	2.80%
All doctors	91,837	133,662	3.80%	4.30%
Consultants	22,324	34,910	4.60%	3.70%
General Practitioners	29,697	37,213	2.30%	3.80%
Qual Nursing Staff	323,457	408,160	2.40%	
Sci Therapy Tech Staff	99,656	142,558	3.80%	
Central Functions	71,079	105,354	4.00%	5.20%
Manager/ Sr Manager	22.693	39,913	5.80%	9.40%

It will come as little surprise that 'Central Functions' and in particular Managers and Senior Managers show the highest growth rates with the recent growth rates of the latter two and a half times that of consultants and accelerating while consultants are slowing. It is noteworthy that consultant numbers have grown at twice the rate of GPs, indicating the determination of government to make the hospital service truly consultant led. The number of honorary consultants in 2008 (2063 head count, 1,450 FTEs) has grown remarkably little since the NHSCA was founded.

Specialist Disciplines

Some idea of the broad distribution of NHS consultants by discipline in 2008 is conveyed in Table 2. Rather fewer than half are assigned to the inclusive medical and surgical specialty groups which are approximately equal in size. It compares them with a comparable analysis of current NHSCA members.

All English and NHSCA consultants by broad specialty 2008

	Engl No	Engl %	CA No.	CA%
Medical Group	7,906	22.8%	280	37.1%
Surgical Group	7,971	23.0%	113	15.0%
Anaesthetics	4,853	14.0%	50	6.6%
Psychiatry Group	4,021	11.6%	119	15.8%
Path & Lab Group	2,346	6.8%	48	6.3%
Paediatric Group	2,211	6.4%	77	10.2%
Radiology	2,269	6.6%	28	3.7%
Public Health	914	2.6%	28	3.7%
Acc & Emerg	819	2.4%	12	1.6%
Dental Group	762	2.2%		
Clinical Oncology	533	1.5%		
Total	34,605		755*	

***699 headcount - some given > 1 specialty**

The Consultant as Manager

Clinical management has come to be the descriptive term applied to the process of medical care. It has entirely benign connotations "for us clinicians". We like to think of it as a well constructed therapeutic plan which embraces many aspects of daily life in addition to the prescription of medications. It has come to include the active participation of the informed patient in the therapeutic partnership. It requires careful explanation, the formulation of alternative courses of action, anticipation of anxieties and misapprehensions and the involvement of many people with special skills and experience. The responsibility for formulating and overseeing the implementation of the management plan rests fairly and squarely with the consultant though careful delegation is often necessary. This activity, which is at the heart of clinical practice, has a single over-riding purpose, the welfare of the patient concerned.

Institutional management inevitably has a different goal. Ideally, it should be the creation and running of organisation that provides optimum clinical care for the largest number of patients. This requires many special skills and capabilities – maximising institutional resources and their efficient allocation among the many demands made upon them, awareness of changing demands, creating a positive working environment, conflict resolution, crisis management, performance monitoring, training etc.

In its earlier days, the clinical professionals took the lead in most of the areas of hospital management which concerned patient care. Their local decisions, after due processing by an official board and executive, were implemented by a group of 'administrators', many of them serving the same institution with remarkable loyalty and dedication for decades. They were displaced by a new generation of professional general managers installed by Keith Joseph in the downturning1970s given powers over the professional staff which in large part triggered the foundation of the NHS Consultants Association.

A further vigorous turn of the management screw occurred when Margaret Thatcher's unheralded NHS review culminated in the imposition on the NHS of her much resisted internal market with all of its paraphernalia of transactional splits, competing hospitals, commercial confidentiality and, above all the imposition of domineering management repeatedly briefed by Ken Clarke and others in Whitehall to show who is now running the show. This was a particularly bitter pill for me.

The Resource Management Initiative (RMI)

From 1986 Guy's had been one of the six sites identified to explore the efficacy of clinical management and the extended role of information technology. The Hospital was split into Clinical Directorates – a dozen or so – each under the control of a Consultant Clinical Director and a Directorate Executive with nursing, technical and secretarial representation. Each Directorate had its own professional managers with primary responsibility and loyalty to their Directorate. The central governing body was made up of all the Clinical Directors plus representatives of central Finance, Nursing, support staff etc. This Clinical Management Committee at Guy's was led by (now Sir) Cyril Chantler.

After some initial struggles, relationships were defined. Policy making was the job of the clinicians (of course very dependent on information and advice from management). Policy implementation

was the job of management. Directorates ran their own budgets and, within limits, made their spending decisions. A very first need was to get reliable information on resource flows and local demands. It took a couple of years to get the archaic finance systems cleaned up and delivering useful data. Soon after we were living within budget, even putting a little aside. The 10 constituent firms of my Medicine Directorate were ultimately given control of their own budgetary segment. Although it was an era of retrenchment and 'efficiency savings', we tried to put our resources to optimum use. No formal analysis of outcome was made but it was certainly a happier ship.

The Internal Market

The experiment was summarily terminated by the arrival of the internal market, ironically much of it being plotted behind the scenes in the hospital. Very quickly, the professionals were subordinated to management. The Medical and Dental Committee which had given a platform to all consultants and had become the institutional parliament calling the Management Committee to account was sidelined and effectively silenced. The threat of the new market managerial bureaucracy was very soon apparent and largely explains the extraordinary phenomenon of the 3,500 UK consultants who agreed to underwrite up to £100 each to cover the costs of the judicial challenge, led by Lord Irvine, to the unlawful installation of the NHS market.

The Consultant and the Specialist

The role of the consultant in respect of long-lasting conditions like diabetes, hypertension, psychiatric disorders, rheumatology and the like is inevitably different from the role of those involved with the more acute disorders or those working in the support subjects like haematology and radiology. This difference is not absolute, however, and all owe their first professional responsibility to the patient. It will however greatly affect their potential links with their colleagues in primary care and it is the nature of these links and relationships which will so greatly affect the coordination and 'seamlessness' of clinical care to say nothing of optimising the use of the paramedical and social services for the benefit of the patient.

The traditional division between the consultant and the community doctor has long been an area of concern, an impediment to optimising care of the patient and an obstruction to developing research into the origins of disease and its prevention. The imposition of the purchaser/provider split as a key element in the market transformation of the NHS has widened and deepened this division. A transactional 'Chinese wall' has been erected between them and it looks like growing ever more impenetrable as financial incentives and penalties are set in place to exercise external controls over the primary care use of the hospital/specialist sector. Payment by Results. Practice and Personal Budgets and profit-sharing schemes will only serve to institutionalise this commercial stand off. While it may prove to be a very effective weapon to exercise local financial control over treasury expenditure on the NHS, it will promote clinical practices, enhance perverse profit-conscious decision making and make even more remote the prospect of patient-centred activity coordinating the use of specialist, primary care and social agency facilities.

An alternative scenario which has found a degree of expression in some Scandinavian and other societies has involved the creation of much closer links between the hospital centre, primary care and the social services. Indeed if the NHS had gone ahead as originally envisioned in the mid to late 1940s, primary care reorganisation would have played a much larger part in the early system with urban health centres placing the centre of gravity of the new service much closer to the community and justifying the proud use of the word Health in its title. It would certainly not have led to wholesale closure of hospitals, filled as they were with victims of acute and chronic infections.

The Clinical Academic Consultant

Another breed of NHS consultant came out of the academic stable, a pathway (if it can be graced with that name) that I had the profound experience of travelling myself. Even less formally structured than the rickety clinical stairway, the would-be academic took his/her life in his hands and after a couple or 3 house jobs started snuffling around for some sort of a post, almost always an externally funded research fellowship of some sort paying a subsistence salary and a bit towards research expenses, sometimes from a respectable source that looked better on a CV but often from a drug company or a research-related charity. The paid academic establishment was small and lived, often on sufferance, alongside its dominant clinical partners whom it affected to despise for their social and financial ambitions to which their appointments had opened the door. The academic unit always carried (and cherished) a substantial clinical responsibility and in return got

honorary NHS registrar status, and if of reader or professorial rank, honorary consultant status. The Royal Colleges played a central role in regulating the consultant ethos; some London teaching hospitals did not even boast a professor of medicine until the 1960s! The fate of the young clinical academics was always uncertain and unsatisfactory. In the late 1950s, Stan Peart newly appointed Professor of Medicine at St Mary's, concerned with this unsatisfactory state of affairs, wrote a personal letter of enquiry to all the professors of medicine in London enquiring about the fate of young academic doctors. One wrote back to him "Some come, some go, who knows, who cares?" Even in the 2000s, academic recruitment remains problematic with rigid training schedules making interchange between NHS and academia more difficult.

The Future Consultant

Looking ahead, the future for the NHS consultant is likely to be much influenced by the political philosophy of the government of the day as well as by more local management decisions about the modes of delivery of care and in particular by the financial incentives, penalties and opportunities that drive the policy making and behaviour regulating activities of Hospital Trust and Primary Care Trust management.

The trend is very much towards the de-emphasis of the acute hospital, transferring as much as possible of the necessary diagnostic and therapeutic activity into the enhanced primary care setting. This is very likely to create new opportunities for the consultant.

The development of the Darzi health centre/ polyclinic initiative could have contributed to this paradigm shift. Of itself, it could be a welcome movement towards a new equilibrium between primary care and the hospital, between the community with its social, behavioural and industrial settings in which much disease originates and the centres of science, technology and advanced clinical skills where the late and end results of disease can be specially tackled. There are intriguing possibilities here for new and enhanced roles for the consultant. Apart from being able to translate procedures and practices into a more patient-acceptable community setting, there are opportunities for aetiological research, for trial and application of primary prevention, for the development of more sensitive and specific methods of early diagnosis.

Even now, the development of such new consultant roles is inhibited by the market configuration of the NHS. Primary care and hospital practice are on two sides of a transactional divide, separated by the purchaser provider split. With polyclinics falling into the hands of profit-seeking private entrepreneurs, the consultant will be driven ever more firmly into doing what is good for business rather than what is best for the patient. Often, one hopes, the two will coincide. When they do not, it is not difficult to guess which will prevail. There are clear advantages to the patient – and to the public – for the consultant in some disciplines to work alongside primary care colleagues in the polyclinic.

Consultant life within the hospital has changed greatly in the past 20 years. The establishment of much tighter managerial control has doubtless reduced some of the abuses that a small minority indulged in but this has been at the expense of the vast majority of consultants who contributed time, effort and commitment well beyond their obligations. There is now a contract based on a fixed number of programmed activities, some clinical, some administrative but inevitably resulting in a more 'clock-watching' working schedule. The pattern of referral of patients between colleagues or even seeing old patients again has been made subject to the financial need for new referrals from the GP. More difficult to quantitate is the effect of the managerial discipline on criticism of the institution but one cannot help but wonder at the silence of the staff of the Staffordshire Foundation Hospital Trust who must have witnessed the abuses alleged over years at the hospital, years in which management succeeded in obtaining their Foundation status! Even whistleblowers' charters are of little avail against a determined managerial regimen.

Conclusion

The way of life of the NHS consultant of the future will be greatly determined by the direction in which the NHS develops. Further development of the finance-based, increasingly profit-driven structure of the Service may in time force consultants to seek economic security and even a degree of freedom of action by contracting their services to the NHS, perhaps through lawyer-like Chambers or via contract agencies. The era of loyalty to the institution, of managerial responsibility for its work and development, of a sense of ownership and respect for the founding principles of the NHS will be seriously at risk. Few consultants want to see things go this way and we must not relax our efforts to arrest the commercialisation and ultimate privatisation of the NHS which now oppresses them.

HARRY KEEN
Guest Editor

Elections

We are approaching a series of elections. The one that involves everybody and will grab the headlines of course is the General Election for a new Westminster parliament.

As we go to press there is no clear indication of what is likely to happen. All possibilities are open, from a small majority for one party or the other, a minority government of either colour, or some form of coalition.

With all the major parties still apparently wedded to the current market system of health care (manifestos not yet revealed but deathbed conversions unlikely), the views of individual candidates may assume a greater importance than usual.

By probing questions to those soliciting our votes we may find some of independent mind prepared to veer from the party line on health care, perhaps aided by increasing public awareness of what is really happening to the NHS.

Those of us who also belong to the BMA will soon be getting information about Elections to BMA Council. As described elsewhere the Council under the Chairmanship of Hamish Meldrum is mounting a vigorous campaign very much along the lines we would wish, so that joint ventures are quite appropriate.

But it would be wrong to conclude that the current BMA position is set in stone. It owes much to tireless work over a long period time by NHSCA members who are also active in BMA affairs and sit on its Council. It is therefore very important that we try to ensure the re-election of those of them who are standing again on this occasion.

We would commend to you:-

Dr Jacky Davis
Mr Peter Terry

Finally, the smaller but not inconsiderable number who are Fellows of the Royal College of Physicians of London will soon have the opportunity to elect the next President, Professor Ian Gilmour's term having come to an end.

There are of course many factors to be taken into account when choosing a College President and Fellows will want to make a careful study of the candidates' statements before ranking their choices.

The College has very strict rules regarding any sort of canvassing so we make no recommendation but merely provide the information that two of the six candidates, **Charles Clarke** and **Richard Thompson**, are members of NHSCA.

The Campaign Against a Market in Healthcare

NHSCA has opposed the imposition of market principles on the NHS from the moment when they first appeared in the White Paper of 1989, entitled in the anodyne fashion characteristic of such publications, "Working for Patients".

That led to the separation between Purchaser (now called Commissioner) and Provider, necessitating an enormous and costly bureaucracy to run its increasing complexities and providing a foothold for the commercial sector which it has not been slow to exploit.

The difficulties President Obama is having in getting his quite modest healthcare reforms agreed should be a warning of what can happen when powerful commercial interests are involved.
It has been an uphill and sometimes lonely battle. It would not be unfair to say that the BMA's position has been variable, depending on the makeup of its Council at the time and perhaps even more so on who is Chair of Council.

Now however, few can be unaware of the vigorous antimarket stance it is taking at this time, which is very gratifying but we understand there is a vocal minority which does not support the current campaign and the leadership needs reassuring that it has grassroots support.

Those of us who also belong to the BMA will recently have received an information pack whose tone and content are very much in line with our own policies. **Feedback is invited and it is vital that we each take the opportunity to strengthen the hand of the BMA leadership by a positive response.**

Elsewhere in this letter Harry Keen sets out the history and results so far of the collaboration between ourselves, other likeminded organisations and the BMA, leading to what we hope will be an influential event in April.

Another example of this is the letter reproduced below which appeared in the Guardian of 2nd February (already seen by those whose email addresses we have).

Politicians need to rethink the role of the private sector in the NHS

For all the pre-election pledges to protect its funding, the NHS is clearly threatened by major cuts. Yet one area of English health policy has apparently remained immune from the debate on cost savings – the main political parties all still cling to the dogma that efficiency in healthcare is best achieved by promoting competition and encouraging the private sector to provide services. As practitioners of medicine and supporters of the NHS, we believe this consensus must be challenged.

The NHS is spending £350 million a year on external management consultants - often at the expense of its own, internal expertise. Repayments to companies profiting from PFI in the NHS are costing the taxpayer billions. There are many examples of Independent Sector Treatment Centres failing to carry out the volume of procedures for which they have been paid. GP-led health centres - often imposed on communities despite a lack of local demand as part of the costly drive to increase commercial involvement in primary care - are struggling to attract patients.

Such examples of public money being wasted are particularly galling to those front-line workers who are being told to gear up for cuts. Moreover, the purchaser-provider split has facilitated the diversion of NHS funding to a plurality of competing interests, and resulted in disincentives for doctors in primary and secondary care to work together to improve services for patients. The experience of other health systems indicates that the creation of an internal market results in a significant proportion of funding being absorbed by transaction costs.

A recent survey by the Economist Intelligence Unit - hardly known for its hostility to business - found that less than a quarter of the UK population believes the NHS would be improved by a greater role for private providers.

We share the commitment of our patients to a health service that is publicly provided as well as publicly funded. It is time for politicians in all parties to re-think their policies on the role of the market in the NHS in England.

Dr Hamish Meldrum, Chairman of Council, British Medical Association

Iain Chalmers, Editor, James Lind Library and cofounder, Cochrane Collaboration

Dr Peter Fisher, President, NHS Consultants' Association

Prof Harry Keen, President, NHS Support Federation

Prof Allyson Pollock, Director, Centre for International Public Health Policy, University of Edinburgh

Prof Wendy Savage, Co-chair, Keep Our NHS Public

Dr Robin Stott, Co-chair, Climate and Health Council

Julian Tudor Hart, Swansea University Medical School

and 14 others. For a full list, see guardian.co.uk/letters

This stimulated a riposte from the Reform organisation, well known advocate of an insurance based service, in the letters page of the Sunday Telegraph.

The BMA's misguided view about the NHS

SIR – Health care in Britain should be a matter for patients and doctors. It should be above politics. For that reason we are concerned that the British Medical Association is campaigning to exclude charities and private-sector companies from our health-care system. Their view is narrow, partial and is not shared by all doctors, many of whom work both in the charitable and private sectors.

The best health services in the world, such as those on the continent, are blind to which type of organisation cares for a patient. They exclude ideological and political considerations and put the doctor-patient relationship at the heart of health care. The large majority of patients do not mind who provides care as long as it is safely and competently delivered.

Furthermore, the introduction of a mixed-funding health care model would promote choice and provide incentives that would allow services to flourish, whether in the public or independent sector. A mixed funding system is in the interest of patients, although it may be less so for those with vested interests in maintaining the status quo.

Andrew Haldenby
Director, Reform
and others

Having been alerted to this Reform letter it was felt important not to let matters rest there so further letters were sent (as below) to the Sunday Telegraph in the hope that at least one would be printed, which we believe it was.

Sir,
I agree entirely with Andrew Haldenby et al that healthcare should be a matter for patients and doctors ('The BMA's misguided view about the NHS', Letters, 7 February).

But this has not been the effect of recent reforms to the NHS in England. The drive to allow commercial interests to profit from the delivery of NHS care has resulted in new layers of bureaucracy, fragmentation of services, and perverse incentives for staff to compete rather than work together. There have been endless reorganisations and numbers of senior managerial staff have increased far more rapidly than numbers of doctors and nurses.

The BMA is not trying to exclude charities and private sector companies from the healthcare system. It is however campaigning for the publicly funded part of the system, i.e. the NHS, to be provided by the public sector.

The concerns of the BMA and of the thousands of doctors who have signed up to our 'Look after our NHS campaign' are rooted not in dogma or vested interest but in pragmatism - we are frustrated by the diversion of resources away from front-line care.
More of the same will not deliver the improvements to the NHS that we all agree are needed.

Yours faithfully

Dr Hamish Meldrum
Chairman of Council, British Medical Association

Sir,
It was predictable that Reform and its adherents would criticize the call by the BMA and many others for a rethink of current health policy in England. Markets have an appropriate place in many aspects of life but healthcare should be a public service, not a commercial market. It is no less ideological and political to advocate it be run as the latter than it is to oppose it.

Whilst it may be true that most patients are not too concerned about who provides their care as long as the quality is good, they are certainly very concerned about how their money is spent. In the difficult economic times ahead, themselves hardly a ringing endorsement of free markets, it is going to be essential that we use the health service budget in the most cost effective manner possible.

What we are advocating is that, instead of being obliged to cut front line services, we follow the lead of the rest of the UK and abandon the vast bureaucracy necessary to administer the artificial separation between "Purchaser" and "Provider" and all that has flowed from it.

We share the view that the doctor-patient relationship should be at the heart of health care and see how it has been damaged by many of the so-called reforms of recent years.

Peter Fisher
President, NHS Consultants Association

It is important that we all take any opportunity which presents itself to keep this topic in the public eye, whether in local or national media.

PETER FISHER

Email Communication

There has been quite a good response to the recent request for members to supply (or update) an email address.

There are still some gaps, so it is not too late for those who have not yet replied as we will be planning to use this method more frequently to inform members about events and issues inbetween the quarterly Newsletters.

For the present, we intend to continue the Newsletter in its printed form as there are members for whom we do not have an email address, many prefer to receive a printed version and there would be logistical problems in having two different forms of distribution.

However as members from time to time wish to show the Newsletter to colleagues who are not members or to others outside the profession, we do now have a PDF version which omits some confidential information such as the names of new members, who have only given their consent for their names to be publicized within the Association. This is available on request, usually very shortly after the printed version.

Where Next for the NHS?

Within months there will be a general election and probably a new Secretary of State for Health. It is a truth universally acknowledged that a new Secretary of State in possession of the Department of Health is in want of a new organisational structure for the English NHS. Indeed all who work in the English NHS have become accustomed to a costly bureaucratic game of musical chairs every three years or so. But one feature has abided in the English NHS since 1991 and that is a belief in the efficacy of the purchaser / provider split. This has endured through four different sets of policies.

- The *'internal market'*, from 1991 to 1997, in which health authorities and GP fundholders (of various kinds) were 'purchasers' and hospitals became NHS Trusts. The aim of the 'internal market' was to drive improvement through competition on grounds of price and quality between NHS Trusts and private hospitals. Although it was promised that 'money would follow the patient', there was no funding system in place to ensure this, so that what tended to happen was for patients to follow the money: i.e. contracts placed by health authorities with hospitals constrained choices by patients and GPs; although GP fundholders were able to use their budgets to choose hospitals.
- The *'third way'*, from 1997 to 2000, which sought to replace the idea of competition with integrated care, based on partnerships and driven by performance. The government argued that the 'internal market' had wasted resources on administering competition. So 'purchasers' became 'commissioners', with the creation of nearly 500 Primary Care Groups within the 100 health authorities, to foster primary-care led purchasing.
- *'Star rating*', from 2000 to 2005, which sought to improve performance of both commissioners and hospitals with the emphasis on performance management by 'naming and shaming' that inflicted reputational damage on those organisations reported to be 'failing' (zero-rated). The government argued that the 'third way' had not worked because this had rewarded failure. 'Star rating' introduced, for the NHS, the radically new idea of a system that would reward success and penalise failure. The government also argued that performance management in this way would be more effective than the 'internal market' which could not work for two reasons. First, patients were reluctant to travel to another hospital. Second, even if they did, and there were consequent movement of funds, if this were to cause problems for the hospital from financial losses, then this threat would be neutered by compensation by the government to avoid the problems of 'destabilisation'. In 2002, Primary Care Groups and their health authorities were abolished and succeeded by about 300 Primary Care Trusts.
- *'Choice and diversity'* from 2002, in which the government returned to the idea of the 'internal market'. The justification being that the target-driven approach was seen as capable of remedying poor standards of performance, but not creating incentives that would lead to a high-performing NHS. As part of this policy, the government introduced four significant innovations that created differences from the 'internal market' : to allow high-performing hospitals to become NHS Foundation Trusts (FTs), with independence from the Department of Health subject to scrutiny of their individual performance by their regulator (Monitor); to finance new Independent Sector Treatment Centres (ISTCs) to provide diagnostic and elective services; to enable patients, in conjunction with their GP, to decide where and how elective care is provided; and implementation of a new payment system 'Payment by Results' (PbR) that paid hospitals a standard tariff for treating the same type of case. PbR did ensure that 'money would follow the patient' and meant that competition, in principle, would not be on price, but on assessments of quality. In 2006, the number of Primary Care Trusts was halved to about 150.

One might hope that after four attempts and twenty years trying to make the purchaser / provider split work we would have learned how to do so and be able to produce evidence of its benefits. The only one of the four sets of different policies that have been tried, however, for which there is such evidence, is that of 'star ratings', for which the purchaser / provider split is essentially irrelevant.

Problems with current policies include:

- The freedom of FTs means that there is no system of governance to ensure supply across health economies.
- ISTCs are more costly than NHS hospitals (and there is the tragic case of a patient dying after an operation with the ISTC not having had blood on site).
- Patients want a good local hospital and are sceptical about the efficacy of the choice policy as a means of securing this objective. And evidence from the US is that patients do not typically switch from hospitals reported to have performed poorly to those that have performed well.
- PbR creates problems for PCTs, as their income is cash limited and determined with reference to a weighted capitation formula that allocates funding by relative need of populations (and not demand).
- Commissioning by PCTs remains weak.
- There are serious problems in handling hospitals in financial difficulties.

Other (small) countries (New Zealand, Scotland and Wales) that have tried the 'internal market' have abandoned this and gone back to health authorities being responsible, within defined areas, for both running hospitals and the health of populations. The rationale is that this reduces transaction costs and can improve quality by better enabling integration of services. This is, however, how the NHS in England was organised prior to the 'internal market' when it was described by Alain Enthoven, an influential visitor from the US, as 'caught in a grip of forces that make change exceedingly difficult to bring about, a "gridlock" of its own'. This was why he proposed the idea of an 'internal market', to overcome these weaknesses. Although he is seen as the intellectual architect of the reforms that followed, he did not advocate the purchaser / provider split. Indeed he sought to create high-performing integrated delivery systems in the NHS, modelled on two successful exemplars in the US: Group Health Cooperative of Puget Sound and the Kaiser Permanente HMO. In comparison he saw a key weakness of the NHS that 'it appears locked forever into a model of separation between GPs and hospital-based specialists' who 'communicate with each other mostly by mail'. He argued for the advantages of multi-speciality group practice 'in which primary care physicians are partners in regular contact with specialists, sharing the same offices, records and equipment' from: a shared comprehensive medical record; easy, quick and informal consultation; a collegial and collaborative atmosphere with formal and informal learning and quality assurance by peer review. Enthoven proposed transforming the district health authorities of the 1980s into such HMOs to provide integrated care for their populations; his 'internal market' would have introduced scope for these health authorities to contract out services if they found their own hospitals to be performing poorly. So ought the NHS abandon the purchaser / provider split and return to Enthoven's original proposal? Although this is a beguiling prospect, there are three reasons why this may prove just as bad as the way the NHS is now.

First, the longstanding distinctive history of the medical profession in England is the gulf between GPs and hospital specialists. There were opportunities with the Thatcher and Blair governments to reshape contracts to try to move towards more integrated care, but these were not taken. And now the NHS enters a period of prolonged austerity, there is no prospect of an opportunity to overcome resistance to the historic division with the extra funding used to finance the introduction of the current contracts for GPs and consultants.

Second, when Enthoven was writing in the 1980s, the assumption was that high-performing integrated delivery systems could be replicated backed by a system of finance by capitation. We now know that assumption was false, as it has proved almost impossible to extend the models of Group Health Cooperative of Puget Sound and the Kaiser Permanente HMO to other areas. Indeed the attempt to do this in the US resulted in the backlash against managed care, and those two HMOs remain exceptions for the physicians who work there and their members.

Third, although Enthoven favoured the idea of competing HMOs for England so that we could choose our own HMO, he saw this as too radical for us. Hence he suggested instead creating non-competing HMOs without choice, so 'membership' would be determined by where we live. Since then, however, the NHS has had an embarrassing sequence of scandalous failures of governance of various parts of the delivery system. Given the US experience that shows it is hard to run integrated HMOs well, to try to impose that model in a another wholesale reorganisation of the NHS in England, would, almost surely, produce a few highly

dysfunctional organisations under incompetent management teams serving populations with nowhere else to go. Introducing Enthoven's favoured model of choice and competition amongst HMOs would pose additional major challenges in system design, regulation and implementation. Indeed it has taken the Netherlands 20 years to develop a system of regulated purchaser competition, and this has so far had little impact on the delivery of care.

So, what ought a new Secretary of State for Health to do, given that current policies and little of what has been tried in the past 20 years has worked well, and the obvious attractive alternative of organisations providing integrated care looks to be so hard to implement throughout the NHS in England? There is benefit in allowing patients choice on principle, but not as a policy instrument to drive improvement. For that the evidence is that this is best achieved by public reporting in ways that cause reputational damage to poor performers. This suggests putting much less emphasis on provider competition and more on systems of performance reporting. In addition we might move from the purchaser / provider split to forms that better enable integration of care. But in doing that we ought to avoid the ambitions of trying to create organisations like Group Health Cooperative of Puget Sound and the Kaiser Permanente HMO throughout the NHS, as few of the organisations that would result would come close to their performance. Instead we might aspire to more modest forms of better integration of care for different types of patients along their care pathways. In this way we will be able to improve outcomes and quality, reduce costs, and also enable GPs and specialists to work alongside each other.

GWYN BEVAN
Professor of Management Science
Director of the MSc in Public Management & Governance
Department of Management

London School of Economics & Political Science
Houghton Street, London, WC2A 2AE
Email: r.g.bevan@lse.ac.uk

An NHS Beyond the Market

Roundtable and Consensus

In September 2008, the executives of the NHS Consultants Association, the NHS Support Federation, Keep our NHS Public and the Medical Practitioners Union agreed to a joint approach to Dr Hamish Meldrum, Chairman of the BMA Council. We proposed a national meeting in mid-2009 to address the subject of 'The NHS in England; Alternatives to the Market' convened by the BMA and with the support and help of our organisations.

We applauded the BMA's vigorous anti-privatisation campaign 'Look After Our NHS' and the publication of its Eight Principles and argued that with Scotland having formally abandoned the NHS Market and its purchaser provider split, in the light of likely financial cut-backs and the coming election, such a meeting would be very timely. Other potential allies – Trade Unions, Royal Colleges, professional associations, campaign organisations and the media had expressed interest and support. One had even offered to help sponsor a meeting itself if the BMA was reluctant.

The BMA response was encouraging though it was not until mid-2009 that Hamish Meldrum got Council agreement. At a first informal discussion he suggested an initial event at BMA House and at his invitation, Peter Fisher, Wendy Savage, Jacky Davis, John Lipetz and I put together a proposal, later discussed and modified at 3 working meetings at the BMA with key members of their Campaign Committee.

We have settled for an initial one-day 'Roundtable Conference' at BMA House on 14th April. Will Hutton has generously agreed to Chair it and about 20 people with informed and constructive views on alternatives to the NHS market are being invited. They will each submit brief position statements and spend the morning in general discussion of these views. The afternoon will see the formulation of an agreed consensus statement for wide distribution.

It is the hope and intention that a final, authoritative consensus statement, backed by a wide range of organisations and individuals, will emerge from the April meeting. With the BMA imprimatur, it will be widely distributed across the country and form the basis for public meetings calling for a new beginning for the NHS and an end to the wasteful market.

HARRY KEEN

National Health Service: Organisational and Management Issues

Introduction: Context

The NHS is large, amorphous and complex. The delivery of care takes place in very differing settings for a wide range of surgical, medical and mental conditions, covering hospitals, primary and community facilities - not forgetting the importance of prevention and the links between health and social care. Effective running of this demanding system is essential to provide the health outcomes that will ensure the wellbeing of the population.

Whilst clearly questions remain about the efficiency and effectiveness of the NHS, there is no doubt that, despite the increase in public expectations and demands on the service, enormous strides have been made in the quality of patient care and in the speed and efficiency of providing diagnoses, treatment and care to patients. The dedication of clinical and NHS support staff remains a central factor but it is very questionable whether the present top-down market style of management is making best use of strictly limited resources. The establishment of NICE (National Institute for Health and Clinical Excellence) and the CQC (Care Quality Commission) were excellent decisions but much more improvement is needed at all levels.

The purchaser/ provider split, introduced by a Tory government, has created the basis for an NHS market economy, significantly developed by the Labour government despite its manifesto commitment to abolish the NHS market. The introduction of commissioners to oversee how the providers operate has replaced the traditional and, in my view, more effective planning and providing system. Further, structural changes by themselves, of which there have been many, do not provide the answer and cannot undo the damage done to the previous planning process.

So, this paper attempts to set out some proposals on management and organisation designed to restore the productive relationship between planner and provider and so improve the effectiveness of the NHS. It examines the situation nationally, regionally and locally, considers how the different levels of management relate to each other and suggests ways in which managers and clinicians can work better together to give the public the health services they need.

Strategic Direction

It is the role of government to give strategic direction to the NHS, to determine its share of national resources, to provide a broad framework of key priorities and set out the objectives and standards to be achieved. The NHS should have the distinctive and separate role of delivering the objectives to the standards set, with government holding the NHS to account. Given these clear distinctions, there should be a national NHS Executive (NHSE) separated from the DoH. It was the Labour government's mistake to combine these two roles. The organisation of public health is a major topic in its own right and not dealt with here but I would recommend the establishment of a Minister of Public Health with a remit to work across all government departments.

The NHSE led by Directors covering the essential functions can then concentrate on its given tasks with the civil servants limited to their Whitehall role. None of this should undermine the ability to make local variations to meet the needs of diverse populations. Just for the record, I am not proposing a government appointed Board to oversee the NHSE. This would simply provide unnecessary oversight of the NHSE which is properly the role of the DoH. Public accountability should be met by a requirement for half yearly reports to Parliament for public debate.

Given the size of the NHS with over one million employees it would then be sensible to use the existing structure of SHAs to give direction and support to the current PCTs and Trusts. Their role, using guidance provided by NICE, CQC and other sources, should include the task of developing best practice for dealing with the full range of conditions and ensure that this is rolled out across their Region. They should also encourage transparency between PCTs and Trusts.

General Management

Any organisational developments within the NHS have to overcome two notable weaknesses. First, the "re-inventing the wheel" syndrome whereby many managers at local level are left to develop new systems/methods for the same purpose in different areas. This practice should be eliminated as a waste of bright managers' talents. This can be done by the SHA bringing the relevant leads

from the PCTs together to develop the appropriate method or by choosing a lead PCT to do this work and then share and improve it by consultation with the relevant managers in the other PCTs. Second, the common reliance on costly "consultants" (whose responsibilities cease immediately after input) to deal with perceived problems needs to be avoided wherever possible.

It has to be said that the purchaser/provider split, with its restrictive contractual and transactional demands, makes management considerably harder than under the planning and providing system. The reason for this is that commissioners are diverted from the real job of management and generally have much less knowledge of the work being carried out at the provider end. Too much emphasis has been placed on setting contracts for all activity: a costly transactional process. Further, the Payment by Results method, which does not adequately reflect the real cost and the differing complexity of care between conditions, often creates activity more driven by the Payment than the Result and therefore less appropriate for patient care. This is not to say that there should not be effective controls on those providing treatment and care. Systems of audit work very well when jointly run by those managing and those providing the services.

The principle must continue to be that the clinician supported by the staff team has the prime responsibility of providing the best possible outcome for each patient. This central purpose should be supported and monitored by managers who have the duty to ensure overall that best value for money is achieved. This can work when there is close working between managers and clinicians. It is therefore necessary to ensure that an adequate number of managers have the training, experience and attitude to fulfil this purpose. Thereby it should be possible to establish an effective rapport and sense of common purpose between managers and clinicians at all levels so necessary for their joint endeavours to achieve the results expected of them. At senior management level, whether national, SHA , PCT or hospital, there should be functional heads of sufficient calibre to drive forward the objectives set. Some of these positions must be held by people with both clinical experience and knowledge of practice at grassroots level. The main functions should be medical (clinical governance), public health (except hospitals), finance, human resources, IT and statistics, provisioning, commissioning (if continued), planning and performance enhancement.

Managing the various Functions

The Finance function has the responsibility for distributing revenue and capital funding to SHAs, PCTs and Trusts according to population needs and the range of activities to ensure its effective use. This is made difficult by the fact that many Trusts provide services for more than one PCT. This is a big enough task without having to get into transaction costs and the whole area of unnecessary and inappropriate tender operations. Funding for capital projects should be established at, say, about 8% of total expenditure to provide for contracts controlled directly by the NHS in order to maintain and improve the quality of NHS buildings. This would avoid the excessive cost and lack of control of PFI projects.

The Human Resources (I prefer Personnel) function has vital duties to perform. An essential role is to develop and maintain an effective strategy for the long-term availability of clinical and non-clinical staff. On top of this is the need to co-ordinate training and development programmes for all types of staff. These continuing functions need to be reinforced from the top recognising the specific needs as well as anticipated changes in certain specialties and places. The routine duties of pay and conditions, including advertising and job selection procedures, should be relatively easy to perform and give support to the other functions. Negotiations on pay and conditions should be taken on by the NHSE at national level by those expert in this field and knowledgeable of the work done at the working end of the organisation. A genuine 'win-win' situation in negotiation might have resulted in less generous settlements for GPs and consultants than the government's recent record. Managers, including those in senior positions, should be subject to the same process.

There are some excellent training programmes for different types of staff but the NHS needs to consider the creation of two types of central training establishments. The first is a Training College for a range of ancillary staff to bring people from different specialties together for a range of purposes to share knowledge beneficial to them and the NHS. At management level there should be a Staff College where management skills and expertise relevant to the NHS can be taught and researched. Further, people should be selected to attend as part of their career development and not on a basis that is decided by individuals or their Trust or PCT - although clearly recommendations can be made. The training function should be brought in-house both to avoid costly outsourcing and to improve quality. Relying on the Health Service Management Centre in Birmingham or the Kings Fund in London - or, indeed, the many Business Colleges - is not enough.

The Provisioning function, involving purchasing,

contracting, storing and distribution of supplies, should again be run by the NHS itself. The purchasing power of the biggest organisation in Europe should be used to obtain the best value and quality for the health service and the country. Competent people should be recruited to perform this function. Indeed, the same should be done for all IT systems.

Organisation and Management at Local Level

Local management needs to be accountable to the public and be able to facilitate the necessary integration of services. Democratic accountability can be achieved by direct election to PCTs or, preferably, by health services being brought under the auspices of Local Authorities. This would ensure better integration between health and social care and give the public and patients a real voice so enabling local people to bring their influence to bear. A preliminary but much less effective measure might be to require Local Authorities to appoint a third, say, of the members of local health boards. An assessment of the accountability of local health boards and Trusts, including Foundation Trusts, would follow such a change.

Integration of services is vital to optimise the development and operation of care pathways and networks for the full range of conditions, particularly those that are chronic and long-term. This requires careful planning by PCTs in consultation with the range of providers in secondary, primary and community care. The recent realignment of stroke services in London will ensure better treatment for those affected. Another example is the introduction of urgent care centres with GPs alongside A & Es to care for patients who do not need the hospital. They give better care at lower cost. These are best run by cooperatives of local doctors who are familiar with their community.

Most general practitioners continue in their role as independent contractors though increasing numbers are employed. The quality of care varies enormously between practices. Raising the quality of primary care requires team involvement in schemes of audit and quality improvement. Management has a key role to play in establishing a constructive and non-threatening monitoring process in such primary care activities. Such a system should provide the much needed thrust to achieve the objective of raising standards while making the GP's task more rewarding. The benefits of high quality continuity of care are clearly in the patient's best interest.

An important benefit from bringing the management of health services under Local Authority control would be better coordination between social care workers and those in the health service. Greater mutual appreciation of their different cultures should result in the emergence of new joint approaches with real benefits for patients.

Conclusion

Not enough consideration has been given to the management and organisation of the NHS despite its pivotal role in ensuring the effectiveness of the service. A different style of management and organisation from the top-down imposition created by a competitive market system is essential for an efficient, effective and humane health service. This paper has set out some of the considerations for a better approach to running the NHS. Its purpose is to encourage debate among clinicians and other staff. Changes should not be introduced in a top-down manner but through consultation throughout the service and with the public.

JOHN LIPETZ
Co Chair, KONP

NHS Rationing

Like most otolaryngologists, I see myself as a specialist doctor who operates when necessary. As disease demographics and patient expectations have changed, so has the volume of elective ENT surgery in the UK. Surgical intervention rates for childhood glue ear have fallen steadily over the past 15 years. Adenoidectomy in England fell by almost 60% from over 16,000 procedures per annum in the late 1990's, to under 6000 in 2008-09. Childhood grommet insertion fell by over 40% - from over 43,300 operations in 1994-95 to under 25,300 in 2008-09, largely due to the better understanding of the natural history of glue ear and the role of 'watchful waiting'.

Similarly, in the last 15 years the rate of tonsillectomy in England has decreased in all age groups from 77,604 in 1994-95 to 49187 in 2008-09, a 37% reduction, due partly to surgeons refining the indications for surgery so that the operation is now only offered to patients most likely to benefit. There have almost certainly also been reductions in the

number of surgical referrals. Against this evolution of more considered surgery, it was shocking to see that, with the stroke of a well pushed pen, a group of nonclinical management consultants should float a scam to save £700m –

"Up to £70om could be saved if PCT's decommissioned some procedures"

2009 report by McKinsey management consultants commissioned by the DH, Extracted from a table published in the Health Service Journal, 10 Sept 2009

"Relatively Ineffective"	Max Potential Reduction in Procedures (%)	Max Potential Savings (£m)
Tonsillectomy	90	45
Back Pain Injections and Infusions	90	24
Grommets (Glue Ear)	90	21

To list but a few of the targeted interventions. Basically what this outrageous proposal suggests is that we could spend less on healthcare if we - delivered 90% less healthcare!! For which tranche of the bleeding obvious McKinsey were paid…..??? Who knows. What we do know is that last year, the NHS paid members of the Management Consultants' Association £300 million. Enough money to buy all tonsil operations for 5 years. Did we miss something? When did the trade of medical costs for management costs become part of the NHS charter?

The managers' suggestion that we axe 90% of tonsil operations conveniently ignores the consequence - a predictable increase in hospital admissions for the complications of tonsillitis - tonsil abscess and severe throat infections. In 2000-01, there were 31,000 tonsil-related admissions for medical treatments. By 2008-09, the figure had risen to 43,641 medical admissions for throat symptoms, an increase of over 40% in England in 8 years. The incidence of admissions for quinsy also rose by 1331 in the same period. Further, a recent Australasian RCP position paper expressed concern that the pendulum appeared to have swung too far away from surgery, such that children with obstructive symptoms now appear to be being undertreated.

The Health Services Journal report was not, however, widely circulated. It was brushed aside by politicians as a one day headline. However, the rationing of interventions continues to be pursued on a wholesale basis – under the banner of "Procedures of limited Clinical Value". Or "Low Priority procedures". The designation of a procedure as of limited clinical value is not remotely evidence based; rather, it is an entirely arbitrary process, akin to the denouncing of citizens under totalitarian regimes. It is of low value because – we – they - McKinsey - whoever – say it is. And the list of Limited Clinical Value procedures is being considered - now. By a PCT near YOU.

At ENTUK we have been shown documents from quite independent areas of the country, citing lists of not only tonsillectomy, grommet insertion and the like, but also surgery for congenital ear deformity, or the implantation of bone anchored hearing aids. The straightening of the nasal septum. The pinning back of protruding ears in school age children. Our response as a Society has been to marshal the best levels of evidence available and to launch and circulate a series of position papers not only to our members but also to SHAs, pointing out their very real clinical value. Others may likewise feel able to pre-empt a negative rating for procedures as diverse as hernia repair and hysterectomy, epidural injection or relief of phimosis, limb prosthesis, prolapse and carpal tunnel treatment – all similarly under threat. The ENTUK position papers are all online at www.entuk.org, and a Specialist society has a useful role, as members can pool experiences, share evidence and launch a response at a national level, hence avoiding local conflicts which may be unpalatable both to the individual consultants and their employing Trusts.

All of this will, however, be utterly to no avail unless we engage the general public in the debate. It is imperative that when lists of Limited or Low Value procedures cross our mailbox or desk, we act urgently to inform those whose services are to be rationed.

JANET A WILSON
Hon Sec ENTUK

Lessons from Nostalgia

The late Sir Douglas Black, Past President of the Royal College of Physicians was NHSCA's first and so far only, Honorary Member.

This article, written in 2002 for the Journal of the RCP, has considerable relevance today and Sir Douglas clearly foresaw many of the problems with which we are now faced.

The present administration has not completely abandoned the policies of the period 1980–1995, which despoiled what was in 1970 a well-functioning and economical national health service (NHS). I had the joy of working as a physician in the service from the beginning until the early 1970s, after which I became a functionary in the then Department of Health and Social Security (DHSS), something which I also contrived to enjoy, but with greater difficulty. From this I was rescued in various ways which are not relevant to the present purpose. But my unusual blend of clinical experience and exposure to departmental administration perhaps qualifies me to be more than a spectator of the present discontents (which are of course magnified by pressure groups and by the media, and also exploited by politicians, often to their unintended disadvantage).

Even apart from the political turmoil, the NHS in 1948 faced real initial difficulties. The demand for care, once it had been made free of cost at the time of need, was grossly underestimated; rancour did not die away overnight and a very large and complex system did not emerge fully armed like Pallas Athene from the head of Zeus. But over the next 25 years the service gained the trust of patients, and the strong support of doctors. However, in the early 1970s new treatments, which were effective but also costly, together with increased ill health in an ageing population, brought increased demand and consequent costs with which funding failed to keep pace.

The National Health Service Reorganisation Act of 1973, introduced by Keith Joseph, was the first major step in a long series of vain attempts to improve function by tampering with structure. This Act abolished the boards of governors, which might have proved a rational way of favouring selected hospitals; and created the short-lived area health authorities. Worse was to come in the 1980s. Advised by a confident manager who apparently could not tell the difference between a business and a service, or appreciate that in a service a consensus style of management might be more effective than 'line management', Margaret Thatcher, the then Prime Minister, set in train the process which led to the disastrous reorganisation of the early 1990s, the central step in which was the introduction of the 'internal market', a device which has helped to give the USA the costliest health care system in the world. These events, which I have outlined briefly, have been described thoughtfully and readably by Charles Webster[1]. Using the extensive material garnered during the compilation of the official history of the NHS up to 1979, he has produced in The National Health Service: A Political History a book which remains authoritative but is free of the shackles of official history.

New Labour deserve credit for recognising, admitting and to an extent palliating the underfunding of the NHS in comparison with other developed countries; and for doing away in part with the internal market – though not, unfortunately, the unnatural divisive 'purchaser–provider' split. They deserve no credit for their enthusiastic recourse to private funding: funding from general taxation is visible, equitable and accountable; private funding is opaque, uncertain, and likely to prove expensive – finance companies are not charities. But the weakest part of the Milburn plan lies in the selection of 'best' hospitals. The 'league tables' focus on the mechanics of health care, which are important, but not the most important aspect of health care, which is outcome. For hospitals, good outcomes largely depend on the relative affluence of the areas from which their patients are drawn, and on admitting from among them, by accident or even design, those most likely to do well. The actual quality of care depends on the calibre, training and morale of doctors, nurses and other health professionals. In comparison, sharp management, keeping the books and public relations 'spin' are of small account.

What might be the key steps in repairing the damage? There can be no rapid fixes, but over time real effort must be made to enhance the professionalism of 'health professions'; to increase their influence on the running of the service; to establish a clear method of handling possible complaints; to remove the internal pseudo-market; to increase local influence on health care; to shift to some degree energy and resources from the pursuit of the bad (a small minority) to the creation and encouragement of the good; and to re-assess the legitimacy of a consumerist approach to health care. Some of these have already been touched on, but I would like to comment more fully on the effect of consumerism on health care, and on the role of health professionals in the NHS.

Consumerism

When I qualified in 1936, paternalism ruled – doctors gave'orders' for patients to 'be under'; and the worst doctors added the insult of arrogance to the injury of a fee. Something had to change; and a milestone on the way came in Ian Kennedy's Reith Lectures[2] in which, speaking as a surrogate for patients, he said:'We must be the masters of medicine'. So now the talk is all of 'partnership', 'fully informed consent' and 'patient autonomy'; and the government show no wish to be left behind in these pursuits. Prior written consent for feeling a pulse or looking at the tongue is apparently on the cards.

Might there be the merest scintilla of a possibility that things might have gone too far in this direction? The work of most doctors entails many consultations with patients (or 'encounters with clients', as sociologists would say). Are doctors to start off by saying, 'Please sign this before I touch you'; or, as seems more likely, will they delegate what to almost every patient must appear as a formality? A lawyer might well question the validity of written consent so obtained, and require 'witnessed consent'. And the consent, however obtained, would be useless in the vast majority of circumstances, and probably invalid when it was actually needed.

When I was in practice, I always saw it as part of my duty to see that the patient understood the nature of their illness, and the rationale for and implications of any recommended procedure. The history, examination and investigations required to establish these matters appeared to me to be justified by the patient's decision to consult me. But the concept of 'implied consent' is anathema to those who look at the ethics of practice through windows.

Waste of time is not a negligible evil to busy people; but there is a more serious objection to exposing medical practice to the full force of consumerism. This has been set out thoughtfully and clearly in a book on clinical judgement[3] written by a moral philosopher and a general practitioner in combination. (The notion that joint authorship with a doctor might be helpful does not often occur to 'opinion formers' on health care.) Kant maintained that 'proper choices' (exercises of autonomy) should be rational; and, using language as a weapon, dismissed choices not grounded on reason as 'heteronomous'. However, J. S. Mill included among proper choices those based on simple preference, with no necessary rational basis. To clarify the distinction, Downie and Macnaughton[3] point out that someone buying shoes can demand a particular pair, even if the salesperson has advised that they are unsuitable; that is the ethics of consumerism. In a medical consultation, the patient can refuse a treatment proposed by the doctor – that is his/her right, but that right does not extend to demanding a treatment which the doctor advises as being unsuitable or even harmful. To say 'yes' to such a demand would be to follow the ethics of consumerism. To say 'no' is proper, even mandatory, within the ethics of professionalism. In the particular case of the doctor–patient relationship, within which the training and experience of the doctor should make him/her the more expert, the professional ethic is surely more appropriate ethically than the consumerist one, as it is less likely to lead to harm. A similar preference could be reached pragmatically, on grounds of health economics, or of the effect on waiting numbers and times used by government as a crude index of 'performance'.

For doctors and others in health care, unbridled consumerism wastes time, and may be a minor nuisance on that account. Much more important are the risks to which it exposes patients. For all the emphasis laid on informed consent, that is much less critical in the all-important outcome than properly informed choice. Such a choice is not best made by surfing the net, or by 'walk-in' or 'direct' facilities; but by discussion with someone who has the necessary training and knowledge to give sensible advice. Of course, there are injuries and ailments for which a simple approach is adequate; and with an established problem 'skill-share' makes an appropriate contribution. But there are also difficult problems, and sometimes what appears to be a simple problem can become difficult; in such cases, a proper consultation early on can save much future trouble.

Professionalism

The image of professionalism is much less important than the actuality, but it may not be insignificant in its influence on public esteem. So it has to be conceded that the professions, and perhaps medicine in particular, are not well portrayed. At one extreme, the 'hospital soaps' display quotidian miracles; at the other, bizarre incidents of malpraxis (and at least one serial killer) are emphasised repeatedly, with no explicit caveat that they are totally unrelated to the actuality of ordinary practice, or indeed to each other. Limited reassurance may come from surveys which indicate little change in expressed views on doctors and nurses. The government, however, appear more susceptible to criticism of doctors by pressure groups and the media, and in response have set up costly surveys and organizations which do little for the generality of health care except to make it more difficult. (I except the National Institute for Clinical Excellence, which at least has a clearly defined function.)

To be a member of a profession is to enjoy a privilege, and to accept a duty, which is to put the interests of one's 'client' above one's own. As always, the ideal is bounded by what is reasonable. That applies to all professions. For the doctor and nurse, individually and collectively, the specific duty is, as Sir Alan Parks put it, 'to maintain clinical standards in the interests of patients'. Now we all at times fall well short of the ideal; but still it is better to have an ideal at which to aim than simply to pursue the main chance. In my view, ideals of the type I have tried to outline have not been supported by the increasingly mercantile and managerial style of the NHS in the past two or three decades.

To give specific examples, when things went wrong clinically the consultant saw the patient or relatives directly, instead of the 'complaints procedure' being formalised and bureaucratised. This did not, of course, annul the patient's civic right of recourse to the courts; but it commonly satisfied (and helped) those whose complaint truly represented a wish to lessen the chance of recurrence of a similar incident. Similarly, consensus management ('Cogwheel' for those who remember it) included an advisory group of doctors, whose views carried some weight; whereas the Griffiths system of 'line management' could be caricatured as a low-resistance channel centred on Whitehall. Local representation was real – appointments committees in our hospital were chaired by a splendid Mancunian called Alderman Onions.

When I entered the DHSS as Chief Scientist, I chose an advisory rather than an executive role, and was much criticized for doing so. But I still believe that people brought into an organisation because of a particular expertise are in a truer, and possible more effective, position if they elect to be advisers rather than executants. Even in the clinical situation they should be giving advice, and not dictating. The same principle applies, I believe, to the role of doctors and other health professionals in the running of the NHS. They should be giving advice, based on their training and experience, not exercising on-line responsibilities for which they have not been trained, even if they may have had a late-life injection of business jargon.

These are serious matters. But relations between'professionals' and 'administrators' used to be informal and unthreatening (as of course they can still be, given a bit of common sense). To give a trivial example, I once told our hospital secretary (formerly in the Civil Service in India) that he should have printed a certain memorandum on rice paper, so that he could more conveniently eat his words.

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SIR DOUGLAS BLACK
MD FRCP, Past President,
Royal College of Physicians of London
Clin Med JRCPL

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Defending the Welfare State and Public Services

Make a space in your diaries for the 10th April when there will be a big march in London in support of public services and the welfare state. This has been initiated and co-ordinated by the National Pensioners Convention, and now has the backing of the major unions including the TUC. The route will be - for those who are not keen on the actual marching element - a shortish one, and will terminate in Trafalgar Square with speeches and all the usual trappings of a good demo.

I have been attending the planning meetings, and am full of admiration for the energy and efficiency of the NPC leaders. I think that - weather as ever permitting - this will be a big turn out, coming as it does in the run up to the election, and encourage as many of you as possible to attend. The BMA will be there with a banner - which brings me to an important question - does the NHSCA have a banner? If not, can we organise one? I don't think there are plans to have the usual generic placards as there will be so many different interests taking part, so an identifying banner is essential to announce our presence. Any volunteers to produce something we can march behind?

JACKY DAVIS

For more details see leaflet enclosed with this Newsletter

Assisted Dying

The Suicide Act of 1961 makes it a crime with a maximum penalty of 14 years to help someone to commit suicide. As doctors, from ethics lectures to periodic BMA statements, we are regularly exposed to the arguments against assisted dying. This article reviews some of the evidence and arguments in favour of assisted dying.

Perhaps the strongest evidence that systems for assisted dying can work comes from the experience of a growing number of countries. Workable safeguards are in operation and a 'slippery slope' has not been experienced.

The Netherlands

- The Netherlands introduced assisted dying legislation in 2002. Patients who have an incurable condition, face unbearable suffering and are mentally competent may be eligible for voluntary euthanasia or assisted dying.
- There are about 3,500 cases of assisted dying or voluntary euthanasia a year.
- Since the legislation has been in place rates of non-voluntary euthanasia (i.e. doctors actively ending patients' lives without having been asked by them to do so) decreased from 0.8% of all deaths in 1991 (1,000 deaths) to 0.4% in 2005 (550 deaths).

Belgium

- The Belgian Act on Euthanasia was passed in May 2002. The law allows adults who are in a "futile medical condition of constant and unbearable physical or mental suffering that cannot be alleviated" to request voluntary euthanasia.

Switzerland

- Voluntary euthanasia is forbidden in Switzerland. However, Article 115 of the Swiss Penal Code exempts people who assist someone to commit suicide, if they act with entirely honourable motives.

Oregon (USA)

- The Oregon Death with Dignity Act has been in place for 10 years. It gives terminally ill people, mentally competent people the option of an assisted death. There is no evidence of abuse or a 'slippery slope'.
- The numbers using the Act to die are low and steady – 341 people have been assisted to die, but many more may have taken comfort from knowing the option is there.

Washington (USA)

- Washington state voted in favour of an assisted dying law modelled on the Oregon legislation (the vote took place alongside the presidential election November 2008).
- 58% of Washingtonians voted in favour of a change in the law in a voter initiative – the law may face challenges (as the Oregon law did when it was endorsed in a similar voter initiative).
- In the first six months after the law was enacted, 28 terminally ill Washingtonians received life-ending medications. One-third of those patients had not yet used the medication, eleven used it to die in the manner of their choosing, and five went on to die of natural causes.

Luxembourg

- In February 2008, the Luxembourg Parliament approved a Law on the Right to Die with Dignity. This allows a person who is suffering unbearably from an illness, and is mentally competent, to request medical assistance to die.

Public opinion in Britain, including religious people, is overwhelmingly for a change in the law respecting assisted dying. Every poll in the last decade has shown between 74% and 87% of the public want the terminally ill to have the right to ask a doctor for a peaceful death.

A recent poll to be published (in Jan 2010) was by British Social Attitudes. It found that seven out of ten religious people think a doctor should be allowed to end the life of a patient with a painful, incurable disease as do nine in ten non-religious people. Overall support was 82%. The views of British doctors about assisted dying do not seem to have been assessed on a representative basis, though votes at the BMA's ARMs show that significant numbers back a change in the law.

An impressive call for a change in British law was made recently by Terry Pratchett in his 2010 Dimbleby Lecture entitled 'Shaking hands with death'. Pratchett, the very successful SciFi author who has previously come out as having a rare form of early onset Alzheimer's dementia, nonetheless wrote a powerful and well argued lecture culminating in a call for assisted dying when he and he alone decided it was time to say goodbye. Pratchett "explores how modern society, confronted with an increasingly older population, many of whom will suffer from incurable illnesses, needs to define how it deals with death."

Judging by the Prime Minister's recent article in the Daily Telegraph arguing against change to the law on assisted dying, it certainly looks as though the PM didn't watch Terry Pratchett's lecture. Alzheimer's and motor neurone disease are examples for which good palliative care doesn't provide all the answers for acceptable terminal care.

A plea of a very different kind for a change in the Suicide Act was made last year by Polly Toynbee after the defeat of Lord Joffe's reforming bill. Toynbee published an article with the title 'The 1961 Suicide Act is an instrument of state torture'. Her argument was that "Every day in hospitals, nursing homes and at home, the state not only permits but orders the torture of the terminally ill. Confined within bodies too frail to help themselves, people are denied assistance from doctors to end their lives peacefully. If anyone counted up the numbers of the dying and the months of agony they suffer against their will in the many dying rooms of the nation's institutions, then the 1961 Suicide Act would emerge as the cruellest torture instrument."

Toynbee argues that it was a "cabal of bishops, rabbis and assorted religious enthusiasts who wrecked the Joffe bill in the Lords through a devious putsch that broke Lords' procedural practice, denying the bill a Commons debate."

The public's and medical views about assisted dying clearly differ, some are for it and some against, but the current law is not a permissive law, it supports only one side of the case. It leaves many people to die in avoidable pain and distress. It is time for change.

PETER DRAPER

(Acknowledgements: I thank Dignity in dying for information about assisted dying in other countries).

The Annual General Meeting 2010

this will be held on

Saturday 9th October in York

The venue will be the mediaeval Bedern Hall, which proved very popular with those who attended the Policy Conference last Spring.

The timings will be similar to previous years but the Executive Committee has decided to defer decisions on the topic and speakers for the afternoon conference until the outcome of the forthcoming General Election is known.

With York's location and good rail connections it is hoped that most members will be able to arrive and depart on the same day. To this end we will be repeating the experiment of having a relatively informal meal together at the end of the afternoon's proceedings, rather than a formal dinner later in the evening.

NHSCA c/o Hill House, Great Bourton, BANBURY, Oxon. OX17 1QH
Phone & Fax 01295 750407
e-mail nhsca@pop3.poptel.org.uk
Website www.nhsca.org.uk