Will the NHS strategic plan benefit patients?

Health policy expert **Donald Light** gives his verdict on the latest plans for the National Health Service

The first principle of the Toyota way, one of the world's most successful management systems, is to base decisions on a long term philosophy that generates value for the individual, society, and the economy.[1] The new strategic plan for the NHS (which, although often called the Darzi report, results from a year long strategic planning exercise involving thousands of NHS staff) is of international importance because it reaffirms the long term philosophy underpinning the original service, to offer comprehensive care free at the point of delivery.[2 3] That philosophy provides the most powerful basis for meeting the health needs of a society in a fair and fiscally disciplined way, especially in the face of increased inequality, rising expectations, advances in technology, and an ageing population.[4]

The NHS puts to shame American access based on insurers' ability to select out risk. The American non-system of competitive commissioning and corporate provision has maximised prices and inefficiencies. About 35% goes to non-clinical expenses. Copayments, top-up fees, and limits on service cost patients thousands a year if they become seriously ill. My father had a bad fall, and home care is costing him \$8400 (£4200; €5300) a month from his savings.

Beyond affirming a solid, long term philosophy, however, the final report of the NHS next stage review does not reflect the 14 principles of "the Toyota way" to manage an efficient and successful healthcare system. Three of its principles, for example, involve thoroughly discussing and considering all sides of a change before introducing it. Careful testing and visible measures of performance must be combined with a culture devoted to identifying problems, analysing their causes, and tackling them before proceeding further, not unlike good clinical medicine.

Instead, the NHS strategic plan begins with an eight page summary letter from Lord Darzi that proposes 33 changes in three loosely constructed clusters. Additional changes appear in the three core chapters on quality, but none of them to my knowledge has been carefully considered from all angles or thoroughly tested. Each is presented as a good idea that will be implemented, then on to the next good idea. Here I will focus on four thematic issues: the continued and costly pattern of "redisorganisation" caused by too many changes not well thought out; the contrast between constant politicised change and experienced clinical leadership; four proposals in the quality chapters; and the future of commissioning.

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The Toyota way

Change overload

The report proposes about 40 changes: new services, new coalitions, new specialised centres, new partnerships, new health centres and polyclinics, new frameworks, new standards, new metrics, new programmes, new clusters, new directorships, a new commission, new advisory groups, a new observatory, and a new board—all under the promise of no new targets or organisational changes because NHS staff are suffering from change fatigue from being redisorganised several times already.[5] Even though every proposed change has some merit, none is critically analysed, and the relations between the changes are not examined. There is no discussion of trade-offs, possible harms, wasted funds, knock-on effects, or assessment as would occur in a careful strategic plan.

Lord Darzi cannot make good on his first pledge, that "change will always be to the benefit of patients," nor the last, that "you will see the difference," because neither he nor anyone else will be able to measure the benefit or the difference of a given change among all the others. Major changes have to date been found to provide little real benefit to patients.[6 7] Unless Lord Darzi proposes a method for evaluating them, these pledges are rhetorical. I predict that the nearly £1bn being wasted on reorganisation will result in comprehensive free care being declared unaffordable and thus requiring patients to pay fees for services and medicines. My recommendation is that the cost of each change be estimated in full, including knock-on costs to other units, and that the source of those costs be specified. Good strategic planning would call for no less.

"Every £10m spent on health centres or polyclinics is £10m less for reducing unacceptable variations in quality"

Need for experienced apolitical leadership

It follows in the Toyota way that a long term philosophy manifested in thoroughly examined management decisions calls for organisations to grow their leaders from within—people who "understand the daily work in great detail" and can teach others.[1] This is why exemplars of integrated and cost effective systems, such as the Veterans Health Administration and Kaiser, the Californian integrated healthcare system that has been serving as a model for NHS reforms, train and nurture the clinical leaders who run them.[8 9] Instead, the NHS is run by politicians who are not experienced clinical managers and feel compelled to impose one undeveloped change after another. No good executive would ever introduce more than a few changes at a time.

By contrast, the tax funded public health service for US veterans is run by clinical leaders. They took ten years to implement one carefully designed plan that transformed the Veterans Health Administration into an integrated care system producing high quality care through constant monitoring and team based improvements—precisely what the NHS wants to achieve.[10] Costs per person dropped greatly. If members of Congress can step back and let experienced clinical leaders reform the administration responsibly, why can't the UK government?

Will quality changes benefit patients?

Improved quality is at the heart of the NHS report. It first proposes health centres "to supplement existing services" by being open 8 am to 8 pm every day and offering a broader range of services. Although this is a good idea (and the way that Kaiser organises primary care), it clearly duplicates the NHS's existing primary care and specialty services.[11] These centres will increase services and demand, driving up costs. Here, quality and equity come face to face through the inverse care law: meeting demand equitably means meeting need less equitably.[12] Need increases with deprivation and inequality, while demand increases with affluence. Every £10m spent on health centres or polyclinics is £10m less for reducing unacceptable variations in quality. Overall, quality will suffer, but invisibly.

Larger, multispecialty health centres could evolve organically at little added cost,[13 14] but the government's approach seems to have another agenda—stealth privatisation. Large companies from what is inaccurately called "the independent sector" (box) are being invited to bid to provide the new centres rather than building up existing general practices. Why? There is no systematic evidence that commercial companies provide better quality more efficiently. To the contrary, 20 years of comparative research has found repeatedly that for-profit corporations cost more (for marketing, corporate overhead, and profits) and provide inferior services.[15] Furthermore, they often do not provide verifiable evidence of better value because they treat performance data as proprietary. Thus these supplementary centres or clinics seem designed to turn over control of primary care to corporations focused on quarterly profits, to the detriment of health inequalities and barriers to access.[16]

Next on the quality agenda is choice. Lord Darzi explains that choice personalises care, but that depends on what "choice" means—choice of hospital hardly personalises a patient's treatment plan. In a Picker Institute survey, hospital patients ranked highest having doctors and nurses who know their history, answer questions, explain clearly, and also wash their hands.[17] Patients ranked choice of hospital 76th and choice of date 74th. Wise patients. Real choice lies in discussing your case with open, knowledgeable clinicians who will not infect you.

Calling the private sector "independent"

The independent sector is a politically loaded term for the private sector. It implies the rest of us are in the dependent sector with less desirable motives. Clear thinking people should not use it. This umbrella term encourages vague thinking about four kinds of organisation that obscures the drive for profits in corporations:

- Investor owned companies (eg, United Health Care, Humana)—Compelled to focus on short term profits by quarterly reports
- Privately held companies (private clinics)—Focus on profits depends on owners. Varies widely
- Non-profit, revenue based organisations (general practices)—Usually focused on service. Surpluses go to more services and possibly perks
- Charitable organisations—Driven by interests of donors of money, time, and skills

Politicised choice and patient led go together to cater to demand and move further away from meeting the needs of people from minority groups or on low incomes. Patient centred differs profoundly and focuses on real need. The choice agenda here is likely to decrease overall quality as it increases variation.

Finally, the star of quality, the National Institute for Health and Clinical Excellence (NICE), is to "expand the number and reach of national quality standards," while local clinical teams are to "develop a wider range of useful local metrics." How will these avoid tripping over each other? Both are to be combined in clinical dashboards that are "updated every 15 minutes." Meantime, each strategic health authority will establish a "quality observatory" to do what reads as roughly the same tasks, and ministers will establish a national quality board. The section exemplifies change redisorganisation.

Weak and limited commissioning

What will happen to commissioning, not mentioned until page 51 of the report? With so many measures, standards, targets, and performance tariffs on top of already existing contractual terms, will there be much for commissioners to do? Drawing on my earlier work and others, Ham concludes there is little evidence that competitive commissioning benefits patients.[18] He pointed out that the government behaves as if it doubts that primary care trusts can commission effectively. Certainly they lack the size, information, expertise, or resources to undertake this challenging job because commissioning was not thought out in the two previous reorganisations or in this one.[19] Primary care trusts were undercut from the start when years of hospital overspends, registered as health authority deficits, were subtracted from their initial budgets. Furthermore, the government keeps increasing the powers and locked-in advantages of large hospitals, bundled Healthcare Resource Groups, and payment by "results" (actually, procedures), all direct contradictions and obstacles to integrated, community based services led by partnerships of general practitioners and specialists.[14 20] What the NHS needs is an evidence based plan for reducing unacceptable

variations in access and quality through geographically based integrated services led by general practitioners and clinical leaders, and paid for by capturing unnecessary millions now wasted on redisorganisation.

The verdict

- The government is still not using good business practice to run the NHS
- Changes are not thought out and usually do not benefit patients
- Change fatigue and redisorganisation continue
- Home grown integrated healthcare services are a promising goal

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1 Liker JK. *The Toyota way: 14 management principles*. New York: McGraw-Hill, 2004.
2 Darzi A. *High quality care for all: NHS next stage review final report*. London: NHS, 2008.
3 Klein R. *The new politics of the NHS: from creation to reinvention*. Abingdon: Radcliffe, 2006.
4 Delamothe T. Centrally funded health service, free at the point of service. *BMJ* 2008;336:1410-2.
5 Smith J, Walshe K, Hunter DJ. The "redisorganisation" of the NHS. *BMJ* 2001;323:1261-3.
6 Audit Commission. *Is the treatment working? Progress with the NHS system reform programme*. London: Audit Commission, 2008.
7 Leatherman S, Sutherland K. *The quest for quality in the NHS*. London: Nuffield Trust, 2008.
8 Light DW, Dixon M. Making the NHS more like Kaiser Permanente. *BMJ* 2004;328:763.
9 Ham C. Improving the performance of health services: the role of clinical leadership. *Lancet* 2003;361:1978-80.
10 Perlin J, Kolodner RM, Roswell RH. The Veterans Health Administration: quality, value, accountability and information as transforming strategies for patient-centered care. *Am J Managed Care* 2004;10:828-36.
11 Kay S. Will polyclinics deliver real benefits for patients? No. *BMJ* 2008;336:1165.
12 Tudor Hart J. The inverse care law. *Lancet* 1971;i:405-7.
13 Dixon M. Will polyclinics deliver real benefits for patients? Yes. *BMJ* 2008;336:1164.
14 NHS Alliance. *In sickness and in health: achieving an integrated NHS*. London: NHS Alliance, 2008.
15 Schneider E, Zaslavsky AM, Milstein AM. Quality of care in for-profit and not-for-profit health plans enrolling Medicare beneficiaries. *Am J Med* 2005;118:1392-400.
16 Pollock A. *NHS plc: the privatisation of our health care updated edition*. London: Verso, 2008.
17 Boyd J. *The 2006 inpatients importance study*. Oxford: Picker Institute, 2007.
18 Ham C. *Commissioning in the English NHS: the case for integration*. London: Nuffield Trust, 2007.
19 Light DW. Is NHS purchasing serious? An American perspective. *BMJ* 1998;316:217-20.
20 Ham C. Competition and integration in the English National Health Service. *BMJ* 2008;336:805-7.

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PERSONAL PAPER

A transatlantic review of the NHS at 60

At the NHS Live conference celebrating 60 years of the NHS at the beginning of July, **Donald Berwick** explained why he admires the UK health system and how it could be even better

"General practice is the jewel in the crown of the NHS. Save it. Build it"

Donald Berwick (below)

Cynics beware, I am romantic about the National Health Service; I love it. All I need to do to rediscover the romance is to look at health care in my own country.

The NHS is one of the astounding human endeavours of modern times. Because you use a nation as the scale and taxation as the funding, the NHS is highly political. It is a stage for the polarising debates of modern social theory: debates between market theorists and social planning; enlightenment science and post-modern sceptics of science; utilitarianism and individualism; the premise that we are all responsible for each other and the premise that we are each responsible for ourselves; those for whom government is a source of hope and those for whom government is hopeless. But, even in these debates, you are unified by your nation's promise to make health care a human right.

No one in their right mind would expect that to be easy. No wonder that, even at age 60, the NHS seems still immature, adolescent, searching.

You could have chosen an easier route. My nation did. It's easier in the United States because we do not promise health care as a human right. In America, people ask, "How can health care be a human right? We can't afford it." As a result, almost 50 million Americans, one in seven, do not have health insurance. Here, you make it harder for yourselves, because you don't make that excuse. You cap your healthcare budget, and you make the political and economic choices you need to make to keep affordability within reach. And, you leave no one out.

"There comes a time, and the time has come, for stability"

Connection and coordination

In the US, our care is in fragments. We don't have a rational structure of interrelated components; we have a collection of pieces. These disconnected pieces cost us dearly. They create what the great health services researchers, Elliott Fisher and Jack Wennberg, call "supply driven care."[1 2] In America, the best predictor of cost is supply; the more we make, the more we use—hospital beds, consultancy services, procedures, diagnostic tests. Fisher and Wennberg find absolutely no relation between supply and use, on the one hand, and quality and outcomes of care, on the other. Here, you choose a harder path. You plan the supply; you aim a bit low; you prefer slightly too little of a technology or a service to too much; then you search for care bottlenecks and try to relieve them.

In the US, we favour specialty services and hospitals over primary care and community based services. Hospitals are abundant, an invitation to supply driven care. Coordinated care, home health care, hospice services, school based clinics, community social services, and mental health services are poorly defended and insufficient. Public health and prevention are but stepchildren. Here, in the NHS, you have historically put general practice where it belongs: at the forefront.

In the US, we can hold no one accountable for our problems. Here, in England, accountability for the NHS is ultimately clear: the buck stops in the voting booth. That is why Tony Blair commissioned new investment in the NHS when he became prime minister, why your government repeatedly modifies policies in a search for traction, and why it chartered the report by Lord Darzi.[3] This is not mere restlessness; it is accountability at work through the maddening, majestic machinery of politics.

In the US, we fund health care through hundreds of insurance companies, a zoo of payment streams. Administrative costs approach 20% of our total healthcare bill, at least three times as much as in England. In the US, insurance companies have a strong interest in not selling health insurance to people who are likely to need health care. Many insurance companies try to predict who will need care and find ways to exclude them from coverage. You do not.

Right choices

You could have had the American plan. You could have been spending 17% of your gross domestic product and making health care unaffordable as a human right instead of spending 9% and guaranteeing it as a human right. You could have kept your system in fragments and encouraged supply driven demand, instead of making tough choices and planning your supply. You could have made hospitals and specialists, not general practice, your mainstay. You could have obscured accountability, or left it to the invisible hand of the market. You could have a giant insurance industry of claims, rules, and paper pushing instead of using your tax base to provide a single route of finance. You could have protected the wealthy and the well instead of recognising that sick people tend to be poorer and that poor people tend to be sicker, and that any healthcare funding plan that is just must redistribute wealth.

Britain, you chose well. As troubled as you may believe the NHS to be, as uncertain its future, as controversial its plans, as negative its press, as contentious its politics, please behold the mess that a less ambitious nation could have chosen.

Is the NHS perfect? Far from it. The recent magisterial report by Sheila Leatherman and Kim Sutherland sponsored by the Nuffield Trust finds some good news.[4] For example, after 10 years of reinvestment and redesign, the NHS has more evidence based care; lower death rates for major disease groups (especially cardiovascular diseases); lower waiting times for hospital, outpatient, and cancer care; more staff and technologies available; in some places better community based mental health care; and falling rates of hospital infection. Other areas show less

"As troubled as you may believe the NHS to be . . . please behold the mess that a less ambitious nation could have chosen"

progress, such as specialty access, cancer outcomes, patient centeredness, and life expectancy and infant mortality for socially deprived populations. The facts are clear and unsurprising: in improving its quality, the NHS is *en route*, and it has a lot more work ahead.

A better service

How can you do even better? I have 10 suggestions:

Put the patient at the absolute centre of your system of care—In its most authentic form, this rule feels very risky to both professionals and managers, especially at first. It means the active presence of patients, families, and communities in the design, management, assessment, and improvement of care. It means total transparency. It means that patients have their own medical records and that restricted visiting hours are eliminated. It means, "Nothing about me without me."

Stop restructuring—In good faith and with sound logic, the leaders of the NHS and government have sorted and resorted local, regional, and national structures into a continual parade of new aggregates and agencies. Each change made sense, but the parade doesn't make sense. It drains energy and confidence from the workforce, which learns not to take risks but to hold its breath and wait for the next change. There comes a time, and the time has come, for stability, on the basis of which, paradoxically, productive change becomes easier and faster for the good, smart, committed people of the NHS.

Strengthen local healthcare systems—What you call "health economies" should become the core of design: the core of leadership, management, interprofessional coordination, and goals for the NHS. I believe that the NHS has gone too far in the past decade toward optimising hospital care—a fragment. Now, it should optimise the processes of care for communities.

Reinvest in general practice and primary care—These, not hospital care, are the soul of a proper, community oriented, health preserving care system. General practice is the jewel in the crown of the NHS. Save it. Build it.

Please don't put your faith in market forces—It's a popular idea: that Adam Smith's invisible hand would do a better job of designing care than leaders with plans can. I find little evidence that market forces relying on consumers choosing among an array of products, with competitors fighting it out, leads to the healthcare system you want and need. In the US, competition is a major reason for our duplicative, supply driven, fragmented care system.

Avoid supply driven care like the plague—Unfettered growth and pursuit of institutional self interest have been the engines of low value for the US healthcare system. Oversupply has made care unaffordable and hasn't helped patients at all.

Develop an integrated approach to the assessment, assurance, and improvement of quality—England now has many governmental and quasi-governmental organisations concerned with doing just that, but they do not work well with each other. The nation needs a clear, agreed map of roles and responsibilities that amount, in aggregate, to a coherent system for aim setting, oversight, and assistance.

Heal the divide among the professions, managers, and government—Since at least the mid-1980s, a rift has developed between the formally organised medical professions and the reform projects of government and the executive. The NHS and the people it serves can ill afford another decade of misunderstanding and suspicion between the professions, on the one hand, and the managers, on the other. It is the duty of both to set it aside.

Train your healthcare workforce for the future, not the past— That workforce needs to master a whole new set of skills relevant to the improvement of health care as a system: patient safety, continual improvement, teamwork, measurement, and patient centred care, to name a few.

Finally, aim for health—I suppose your forebears could have called it the NHCS, the national health care service, but they didn't. They called it the National Health Service. Maybe they really did mean to create an enterprise whose product—whose purpose—was not care, but health. Maybe they knew then, as we surely know now, that great health care, technically delimited, cannot alone produce great health. The high profile epidemics of severe acute respiratory syndrome (SARS), bovine spongiform encephalopathy, and avian influenza cannot hold a candle to the damage of the durable ones of obesity, violence, depression, substance misuse, and physical inactivity. Would it not be thrilling in the next decade for the NHS to fully live up to its middle name?

The only sentiment I feel for the NHS that exceeds my admiration is my hope. I hope you will never, ever give up on what you have begun. I hope you realise and reaffirm how badly you need—how badly the world needs—an example at scale of a health system that is universal, accessible, excellent, and free at the point of care—a health system that, at its core, is like the world we wish we had: generous, hopeful, confident, joyous, and just. Happy birthday.

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1 Fisher ES, Wennberg DE, Stukel TA, Gottlieb DJ, Lucas FL, Pinder EL. The implications of regional variations in Medicare spending. Part 1: the content, quality, and accessibility of care. *Ann Intern Med* 2003;138:273-87.

2 Fisher ES, Wennberg DE, Stukel TA, Gottlieb DJ, Lucas FL, Pinder EL. The implications of regional variations in Medicare spending. Part 2: health outcomes and satisfaction with care. *Ann Intern Med* 2003;138:288-98.

3 Darzi A. *High quality care for all: NHS next stage review final report*. London: Department of Health, 2008. www.dh.gov.uk (search for: 10106).

4 Leatherman S, Sutherland K. *The quest for quality: refining the NHS reforms*. London: Nuffield Trust, 2008. www.nuffieldtrust.org.uk/publications/detail.asp?id=0&PRid=389.

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