Time for a healthcare reformation
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There is arguably no more significant issue than the future provision of healthcare. No more important debate than exactly what role the state should play in both the provision and purchasing of healthcare. No greater challenge than the extent this can be afforded, over the next decades, by the taxpayer.

Our growing and ageing population, the costs of new drugs and treatment, and the impact of lifestyle choices, are all going to put intense pressure on both the National Health Service in the UK and international healthcare systems alike.

In the UK, our admiration for a free NHS based on need, not ability to pay, is unequivocal and unyielding; however, the necessity for reform is becoming ever greater and more urgent. The last 18 months have been a period of significant and intense debate about the provision of healthcare, and the future of our health service.

Listening to the recent debates in the UK Parliament, some would believe that the NHS is flawless and provides a utopian service, others press genuine concerns, and others fight for vested interests. The Health and Social Care Bill, whilst a step in the right direction, is not a comprehensive panacea for all the challenges the NHS faces in the next ten to 20 years.

It is not going to be possible or desirable for the NHS to continue in its current form. It must evolve. The financial stress from population pressures, disease prevalence, macroeconomic difficulties, and technological and pharmaceutical advancements, means that the provision of healthcare will have to be more efficient, focused and patient centred, driven by patient outcomes not processes.

Whilst current reforms are moving the health service towards the patient, we should go further. There must be changes internally to alter attitudes and to facilitate and encourage innovation, calculated risk-taking and integrating care, none of which have been historically good in the NHS. The Government has a role to play in facilitating this change and ensuring that resources are available to achieve the highest quality of healthcare, whilst improving both patient outcomes and value for money for the taxpayer.

The reforms will rightly encourage and facilitate patient choice, and enable a regulated degree of competition based on quality, not price. The Coalition has rightly protected departmental expenditure, but demanded better value for money for tax payers. This will enable a greater proportion of resources to be reallocated and realigned to front line patient care, driving quality and patient outcomes. However, if we are to protect the highly-valued NHS, free at the point of use, we must meet the fundamental challenges that remain:

- Poor productivity, particularly in the acute sector.
- Too little innovation.
- Minimal clinical involvement in commissioning and decision-making.
- Sub-standard outcomes across a range of clinical indicators.
- Weak commissioning of services.
- A distinct lack of willingness to decommission or re-configure poor service provision.
- Insufficient information to enable patients to make informed choices and.
- A lack of support to provide patients with an option to stay at home, especially those with long term conditions.

There are several policy responses that need to be seriously considered. Firstly, whilst there is excellent care provided within the NHS family, generally the NHS is still not centred on the patient. It is with great frequency that incidents of poor and inadequate patient care are reported. All those providing healthcare should be focused on the patient, and we should consider NHS managers being partially rewarded on patient satisfaction and experience. This is a significant mechanism that will provide focus – with senior managers touring the wards, checking on patient experience, satisfaction and needs and responding accordingly. There will, of course, be resistance; but, currently, all too often the patient is revolving around the system, not at its centre. We must not forget that the patient is the user of the service.

Secondly, we must alter the way funding flows through the NHS, not just to reward outcomes instead of activity, but to move the funding away from episodic care towards pathways. This will encourage integration, which to date has been poor (and should not be about provider organisations integrating). In addition, we must further financially incentivise integration by facilitating integration pathway “commissioners” to purchase integrated care on behalf of patients, and to take responsibility, and be rewarded, for the quality of integrated care and the whole patient journey, not siloed condition care. Integration must not be allowed to be an excuse for maintaining poor quality providers.

Thirdly, we need to encourage and enable a much greater involvement of the independent sector, social enterprises, mutuals, charitable, voluntary and the private sector, in providing care. It is not acceptable that poor quality care be allowed to continue purely because it is provided by the state, or any other provider. The provider that delivers the best outcomes, irrespective of ownership model, should be the preferred provider, and the childish argument about state vs. independent sector should cease. All providers, irrespective of social, economic
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and financial models, have the potential to play a role within the NHS family, enhancing patient choice and quality of care.

Fourthly, we must recognise that the NHS is not an efficient organisation. Productivity has collapsed in hospitals, and there is significant waste and duplication in the system, as well as inefficient use of NHS real estate. The procurement process is nothing short of a shambles, and a much more sophisticated system needs to be put in place. Transparency is key to ensuring that patients and commissioners can see, at any time, comparable information, showing clearly, in an understandable way, what the costs are across different trusts and providers. Under these circumstances, the massive efficiency disparities that currently exist would be exposed, highlighted and then disappear. In turn, resources would be freed up to be re-invested in front line care.

Fifthly, there needs to be an information revolution allowing patients access to their own records, with each patient having one NHS number to enable interoperability. Patients must have access to comparable and easily understood information to inform choice, e.g. hospital acquired infections on a ward-by-ward basis, outcome levels and patient satisfaction. Patients should not have to be reliant on accessing relevant information via the internet. Information should be taken to them. Coaching centres in the US are an excellent model, where nurses speak to patients with long term conditions – not only assisting them with information to discuss with their doctor, but also providing support and enabling them to stay out of the expensive acute sector and remain at home, supported by community services.

Finally, accountability – as local commissioning takes hold and the patient is genuinely empowered via information, competition and choice, central accountability will weaken. Local accountability must strengthen. Just as we are moving to local democratic accountability with the police service, so we should consider direct elections for local Health Supremoes, democratically accountable and chairing local Health Boards, responsible and accountable for the Joint Strategic Needs Assessment in a locality. It would be preferable if the Supremo were a clinician.

Dramatically improving quality of care will require a relentless determination both by government and clinicians to ensure that resources are finding their way to patient care. There needs to be a specific focus on decommissioning poorly performing services, and commissioning alternative providers. This must include, in some cases, new players taking over failing services, with clinicians playing a leading role. Furthermore, there needs to be a drive to reduce the significant wastage in medicines. In this area, both individual patients and GPs have a responsibility.

The most difficult change to be made is to alter the culture of the NHS. It is imperative that we move away from the current risk-adverse atmosphere prevalent in large sectors of the NHS, and, instead, facilitate and encourage innovation and dynamism, and allow an arena for new ideas and working practices to flourish.

Expediting the take-up of successful innovation is key. All these challenges and the necessary changes will involve some difficult decisions, which clinicians will have to front, particularly as it relates to reconfiguration of services.

The NHS is a national religion, and as such deserves our wholehearted support, but if it is to survive as a taxpayer-funded service, free at the point of use and based on need not ability to pay, it must change. The next 10 to 20 years should be about patient-centred reform, delivering better quality healthcare to the patient, and better value for money for the taxpayer, allowing our much-loved NHS to survive and thrive.