Lessons from the past decade for future health reforms

The National Health Service in England has been on a rollercoaster ride of reform for over a decade. The journey started in 1997 with the white paper, *The New NHS*, and continued through the introduction of performance targets and standards. New systems for inspection and regulation were then introduced, followed by reforms to increase patient choice and competition. The most recent changes focus on quality and safety with improvement being led locally by clinicians (box). With a general election expected in 2010, and the opinion polls indicating the likelihood of a change of government, further reform seems inevitable. I have identified 10 lessons for policy makers from the experience of the past decade.

**Policy making in opposition is often weak**

When I make presentations about the NHS reforms to managers and clinicians, one of the first questions I am asked is, did the Blair government have a master plan for the NHS when it was elected? The answer of course is no.

When it was elected the Blair government had a clearer idea of what it was against than what it was for in the NHS. The first six months of the new government were taken up working through its own policies for the NHS. The evolution of NHS reform since 1997 is better seen as an example of policy making on the hoof, or in the language of policy analysts, an exercise in policy learning,7 than as a premeditated programme of planned changes.

The first lesson is therefore the weakness of policy making in opposition and the failure of political parties to invest time and effort in working through their plans to enable them to put their ideas into place when elected into government.

**Politicians are inexperienced in making large scale change**

The second lesson is the inexperience of the current political class outside politics. The importance of this is that when members of parliament become ministers they bring little if any track record with them of management and leadership in other sectors. When one of these politicians becomes executive chairman of Britain plc and another becomes executive chairman of one of the most complex healthcare systems in the world, they take on responsibilities of a different order from those they have previously exercised.

Of course, they are able to call on advice from civil servants, special advisers, and many others, but few of these individuals have leadership experience in an organisation that comes anywhere near the size and complexity of the NHS. It is therefore hardly surprising that new health ministers struggle to understand the potential and the limits of the powers at their disposal and take some false turns along the way.

**It takes time for the results of reform to become evident**

The Blair government became serious about reforming the NHS only when Alan Milburn was appointed as secretary of state for health in October 1999 and the prime minister made his commitment in January 2000 to bring spending up to the European Union average. At that time the government strengthened its approach to targets and performance management and the NHS Plan set out a road map for the next 10 years. Yet within 18 months of the prime minister’s announcement on spend-
was making real progress towards the objectives set by government.

The implication for people leading major change programmes is the need to focus on established priorities and to be constantly alert to the likelihood that new problems will arise. This requires well developed intelligence systems that connect the people responsible for steering reform nationally with managers and clinicians delivering services on the ground to provide feedback on important operational problems as they arise. It also demands a capability for strategic policy making in government focused on scanning the horizon for new threats and opportunities.

Changes in leadership may impede progress

Although leadership changes may help to accelerate reform in some circumstances, in others they may impede progress. Looking back, the period from 1999 to 2004 was unusual in that a small group of individuals at the centre of government exerted a powerful and consistent influence on the direction of reform. At the core of this group were the prime minister, the secretary of state for health, and their special advisers.

The importance of these individuals, and especially those at the core, was that they worked from a common script on the reform of the NHS and functioned tirelessly to ensure that it was carried into action. The group began to unravel when Alan Milburn resigned unexpectedly in June 2003, and it suffered a major loss of momentum in 2004 after the departure of Simon Stevens as senior health policy adviser to the prime minister. The pace of reform slowed as a consequence.

NHS reform requires a combination of approaches

In the messy reality of public service reform, a combination of approaches is likely to be necessary. The evidence shows that targets and performance management have clearly had a big impact on the reform of the NHS. Regulation and inspection are also contributing, as seen in the improvements in performance achieved in the annual health check. Most independent observers think that the quasi market has yet to make a tangible difference, although it may be too early to reach a considered judgment given that the reform is still being implemented.

Each of these approaches has weaknesses as well as strengths. In the case of targets and performance management, the main weaknesses are the disempowerment of front line staff, the stifling of innovation, and the risk of gaming. In the case of regulation and inspection, there is the danger of overload on the organisations providing care to patients. And the main drawback of the quasi market relates to the need to use competition with discrimination in the NHS, recognising that collaboration and partnership also have a role (see below).

Regulation and inspection are likely to become increasingly important

If politicians are serious in their stated commitments to reduce reliance on targets and performance management and continue to struggle to make the quasi market work, regulation and inspection will become more important. With the number of NHS foundation trusts continuing to increase, the drive for improved performance that was previously exercised by the Department of Health will come from Monitor and the Care Quality Commission, especially at a time when the commissioning of services by primary care trusts remains a work in progress. Much therefore hinges on the performance of the regulators and their ability to use their powers to take the NHS to the next stage of development.

Policies are needed to support collaboration alongside competition

The diverse nature of NHS services means that different approaches to reform need to be matched to different services. Under the Blair government, policies on choice and competition were developed primarily to support the government’s main aim of reducing waiting times for planned care. With ministers concerned to increase hospital activity to improve access to care, it made sense to offer patients the opportunity to go to the hospital of their choice and to use the payment by results reforms to ensure that money followed patients’ choices.

It is much less clear that these policies will help support improvements in other priority areas, such as care for people with chronic diseases and unplanned care, where collaboration may be more important than competition. The levers and incentives to support
increased collaboration between primary and secondary care and between health and social care are much weaker than those used to promote choice and competition. This creates a major challenge since most beds in NHS acute hospitals are occupied by patients who are admitted as emergencies rather than from the waiting list.\(^\text{11}\)

To express the point in colloquial language, there is a clear risk of the planned care tail wagging the NHS dog, and future policy needs to tackle this urgently. Collaboration should be encouraged by building on the new integrated care pilots\(^{12}\) and by supporting the development of networks of providers in areas such as urgent care and care of older people. England may be able to learn lessons on collaboration from Northern Ireland, Scotland, and Wales, as well as from integrated systems of care outside the United Kingdom.

**Front line staff, especially doctors, need to be fully engaged in reform**

Whatever combination of approaches is used, there is a need to find ways of engaging front line staff in the process of reform. While I was working in the Department of Health, I wrote an article reflecting on the limited effect of “big bang” healthcare reforms in different countries.\(^{13}\) At the heart of my argument was the contention that these reforms had not lived up to expectations because they had failed to make a real difference to the day to day decisions of front line staff. These ideas only really came to the fore in Lord Darzi’s next stage review, with the argument that reform should be driven locally and led by clinicians.\(^{5}\)

Currently the NHS lacks many of the skills to make change happen.\(^{14}\) Reform that is driven locally will lead to slow and uneven improvement unless priority is given to equipping staff with the project management and service redesign skills that are required to take reform forward. A Canadian study of high performing healthcare organisations in different countries identified building capability for change and improvement as a key characteristic of the organisations studied.\(^{15}\) In the next stage of reform the NHS needs to act on this finding.

**Conclusion**

These lessons have been distilled from experience of over a decade of reform in one country’s healthcare system. Their relevance to other systems needs to be explored through comparative analysis, and their applicability to health reform in England in future is an empirical question that it will soon be possible to assess. For those concerned to improve policy making, the most important question, to invoke Santayana, is whether politicians are able to learn from history or are condemned to repeat it.

**Competing interests:**

Unit in the Department of Health between 2000 and 2004.

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**PICTURE QUIZ**

**Dyspnoea and cough in a toddler**

1. The chest radiograph shows a gas filled structure above the right hemidiaphragm and midline (fig 1). Opacification and atelectasis are also present in the right lower zone. The left lung field is clear and the heart and mediastinum are normal.

2. The most likely diagnosis is a (congenital) diaphragmatic hernia accompanied by right middle lobe collapse or consolidation. A less likely differential diagnosis is a hyperexpanded lobe caused by a congenital lung abnormality, such as a congenital cystic adenomatoid malformation. The gas filled structure on the radiograph is the stomach, which has entered the chest as part of a paraoesophageal diaphragmatic hernia.

3. Upper gastrointestinal series with water soluble contrast material will confirm the diagnosis, but lateral chest radiography (fig 2) or computed tomography of the thorax and upper abdomen may also be helpful.

4. The presence of a paraoesophageal hernia in a young child is a rare but important finding, which carries the risk of the serious complications of organoaxial volvulus of the stomach or colonic herniation. Morbidity from chronic gastrointestinal or respiratory symptoms or from iron deficiency anaemia secondary to gastrointestinal blood loss are possible long term problems. Prompt surgical repair—reduction of the herniated viscera, excision of the herniated sac, and tightening of the crura of the oesophageal hiatus—is therefore indicated.

**STATISTICAL QUESTION**

**Matching**

**b**