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The NHS in the age of anxiety
RHETORIC AND REALITY

A dangerous gap is opening up between rhetoric and reality as the NHS faces a grim fiscal future, **Rudolf Klein** argues. High flying ambitions for transforming the NHS are not matched by achievement, and austerity will compel a new agenda of minimising harms rather than maximising benefits

Rudolf Klein spent the first half of his career as a journalist with the *Evening Standard* and the *Observer* and the second half as professor of social policy at Bath University. He is a fellow of the British Academy and of the Academy of Medicine and has been a visiting professor at the London School of Economics and at the London School of Hygiene and Tropical Medicine. He has written extensively about health policy and is a long standing contributor to the *BMJ*. The seventh revised and updated edition of *The New Politics of the NHS* will be published this autumn.

Statistically there does not seem to be much wrong with the National Health Service. At the turn of the year, the Department of Health could report that "key performance standards" had been maintained even as fiscal austerity began to bite.[1] Some, such as hospital infection rates, had even continued to improve. Further, the department expected the NHS to have passed the halfway mark towards achieving its £20bn (€23bn; $31bn) savings target by the end of the 2011-12 financial year.[2] A more recent sample survey also suggests that there has been no deterioration in performance, bar a marginal increase in the number of patients waiting for more than four hours in emergency departments.[3]

Organisationally, too, the NHS seems to be a success story. It has successfully implemented the disruptive and distracting Lansley programme of change. This involved closing down 170 organisations, creating 240 new ones, making 10 000 staff redundant, and then re-employing 2200 of them.[4] NHS England, as the NHS Commissioning Board has chosen to style itself, is now in charge of the service, churning out instructions, consultations, and exhortations at a manic rate. Yet it would be surprising if the public and patients noticed any difference in the way the NHS operates, so smoothly managed has been the transition; it is those working in the service who have absorbed the shocks and pain of change.

Bad news stories

But, of course, there is another story to be told: that of the NHS stumbling into crisis. The three volumes, 1781 pages, and 290 recommendations of the Francis report into failings at Mid Staffordshire trust[5] fell heavily on the public consciousness. If so many changes were needed in order to ensure patient safety, what had gone wrong with the NHS? If a cultural revolution was called for, what did this say about the staff of the NHS and the system within which they worked? Subsequently the Keogh review confirmed anxieties about standards, even while being careful to avoid making dramatic recommendations on the basis of a small sample of trusts.[6] And the launch of a campaign by the chief nursing officer to promote "compassionate care" provided little reassurance.[7] If a campaign was needed to promote such core values, what had happened to the NHS?

Then there is the drip of bad news. NHS Direct withdrew from its contract as a major provider for the NHS's newly revamped telephone advisory service for the public, raising doubts about the viability of a project designed (among other things) to prevent panic visits to emergency departments. Barts Health, the country's biggest NHS trust, brought in management consultants to help it deal with mounting financial losses; staff cuts are expected. The House of Commons Health Committee reinforced anxiety about emergency services in a highly critical report.[8] And so on. Above all, it became clear that the fiscal squeeze on the NHS was getting ever tighter and set to continue into the indefinite future, as the target of achieving £20bn savings by 2015 to fund demographic and technological pressures out of a standstill budget was raised to £24.25bn to be achieved by 2016.[9] Ministers, of course, find justification for their policies in the fact that the NHS seems so far to have survived both organisational turmoil and fiscal austerity without any conspicuous deterioration in performance. Conversely, their critics pick on the signs of a system under stress as the indictment of unnecessary organisational change, compounded by an excessive emphasis on competition. Given the impossibility of separating out the effects of the government's organisational policies for the NHS from the impact of fiscal pressures on the service, I will not attempt to adjudicate between the competing interpretations. In any case, given that variation within the service is the norm and that different dimensions of performance do not necessarily march in step, it is possible to make two contradictory statements about the NHS, both of which will be true. Instead, I will focus on three areas where a dangerous gap seems to be opening up between rhetoric and reality.[10]

If achieving change in the NHS was difficult in the years of plenty, it becomes doubly so in the age of austerity

Swimming through treacle

What the NHS needs, everyone agrees, is "transformational change." The prescription is clear. Specialist services have to be centralised; community based services have to expand to reduce demands on hospitals; there has to be greater integration; the mutual interdependence of health and social services has to be recognised. There is little new about this programme. The various policy themes can be traced back over the decades. So, for example, the reorganisation of the NHS in the 1970s was in part driven by the desire to facilitate cooperation between health and social services, while in the 1990s an ambitious programme for improving primary care services in London was launched in the hope of reducing the capital's over-reliance on hospitals. The new element is a sense of urgency: without such "transformational change" how is the NHS to survive in the age of austerity?

But reality is lagging behind rhetoric. Successive reports from the House of Commons Health and Public Accounts Committees have shown that it is the freeze on NHS pay and the reduction

in the prices paid for healthcare that account for most of the savings so far achieved. Too often the measures taken, the health committee argued, "represent short-term fixes rather than long-term service transformation."[11] "The Department has not yet convinced the public or politicians of the need for major service change or demonstrated that alternative services will be in place," the public accounts committee concluded,[2] while also pointing out that "The existing payment mechanisms in the NHS were designed to incentivise hospitals to carry out more activity, and do not drive service transformation."

Transparency and surveillance may help to drive up overall NHS standards. But the more every aspect of NHS activity is unveiled, the more likely is the revelation of the occasional inadequacy

The difficulty of achieving change should come as no surprise. In many respects the NHS is a constituency for the status quo: witness the coalitions of professionals and public that mobilise to resist threats to local services in campaigns which may stretch over the years. If the NHS's resilience in coping with organisational turmoil, noted earlier, is one side of the coin, its ability to absorb change without greatly changing is the other. Thus both Margaret Thatcher's introduction of the internal market[12] and Tony Blair's resurrection of it[13] disappointed the hopes of their advocates and confounded the fears of their critics. The NHS did not become a model of efficiency overnight; nor did it become a competitive jungle.

If achieving change in the NHS was difficult in the years of plenty, it becomes doubly so in the age of austerity. In the years of plenty, new developments—investments in primary care, say—could be funded out of the annual increments in the NHS's budget. Everyone could gain. Now it has become a zero sum game. Inevitably there must be losers.

NHS chief executive David Nicholson and his colleagues at NHS England must surely be more aware than anyone that exhortation alone will not remove obstacles to change. But the rhetoric of transformation has yet to be translated into an analysis of how to overcome the institutional obstacles and perverse incentives that stand in the way of its achievement, let alone into the political will to risk the unpopularity that might be involved in, say, streamlining the process of closing down services.

Overflowing ambitions

The gap between rhetoric and reality in the case of "transformational change" becomes a yawning chasm if we turn to the government's mandate for the NHS.[14] The mandate is the key document in the new, hands-off relationship between the secretary of state for health and the NHS. It is, in effect, a contract defining what the secretary of state for health expects NHS England to deliver by 2015. It sets out the outcomes that the NHS is expected to achieve and thus defines the currency of accountability against which the performance of not only NHS England but also clinical commissioning groups will be judged.

In many respects the mandate is a welcome and radical innovation. It replaces targets with outcomes. It makes the government's policy goals explicit: if, in the first place, the mandate is a tool for ministers to call the NHS to account, it can in turn be used to call ministers to account for their stewardship. Moreover, the five priority areas where the mandate expects "particular progress to be made" offer reassurance to those who see the coalition government as a set of hard nosed privatisers, intent only on dismantling the service. The priorities are improving standards of care, and not just treatment, especially for older people and at the end of people's lives; the diagnosis, treatment, and care of people with dementia; supporting people with multiple long term physical and mental conditions; preventing premature deaths from the biggest killers; and supporting people with health conditions to remain in or find work.

In addition, the mandate sets a number of more specific objectives for NHS England, such as ensuring that the NHS becomes "dramatically better" at involving patients, that the incidence and impact of postnatal depression "is reduced through earlier diagnosis and better support," and that everyone will have online access to the health records held by their general practitioners by 2015. The list could be extended; the point is simply to illustrate the variety and width of the policy ambitions set out in the mandate. And crucially progress towards achieving those ambitions will be measured using the NHS Outcomes Framework[15]: a compendium of indicators. NHS England will be required to "demonstrate progress" against "all of the outcome indicators in the framework—including, where possible, by comparing our services and outcomes with the best in the world."

In a world of plenty, with NHS budgets rising year by year, this programme would rightly prompt cheers. How realistic is it, however, to expect the NHS to improve on so many fronts in the age of austerity, when simply maintaining existing services and quality will be an achievement? True, the mandate does not specify how much progress will be expected. There is wriggle room. But there is no attempt to specify an order of priorities between competing policy objectives. If choices have to be made between the many desirable objectives set out in the mandate—as they surely will—what are the criteria to be used?

Instead of answering this question, the mandate offers only the rhetoric of all embracing, aspirational ambitions. It contrasts starkly with the bleak warning that the "challenges of the future . . . threaten the sustainability of a high quality health service," from Nicholson and the chief executives of a gaggle of NHS agencies when launching a national debate about the future of health and care provision in England.[16] Some "tough decisions" are required, they argue, if the NHS's future is to be guaranteed, even while excluding consideration of what may turn out to be the toughest decisions of all—such as, whether more income should be generated by charges or the whether the scope of NHS services should be cut back.

The government has been trawling for public views about "refreshing" the mandate. But it is not refreshing but shredding that is needed if the mandate is to close the chasm between rhetoric and reality. A new document might start by addressing the question of how "tough decisions" will be taken and by whom: will ministers take responsibility or are they hoping to cascade responsibility (and blame) down the line in the name of devolving power and promoting local autonomy?

Paradox of plenty

Two intertwined themes have shaped much health policy rhetoric and action over the past decade and more. On the one hand there has been the quality theme. On the other hand, there has been the patient empowerment theme. The common element has been an emphasis on transparency, and the outcome has been a statistical strip tease by the NHS, unveiling its activities in ever greater detail. Not only is more information available than ever before, but it is also more accessible than ever before.

The logic driving this development is persuasive. Transparency exposes poor quality care, while the threat of exposure helps in turn to prevent it. Data about hospital performance not only informs patient choice but also acts as a spur to quality improvement as patients gravitate towards consultants and hospitals with the best record. The arguments for greater transparency in the name of quality and patient empowerment are mutually reinforcing. Unsurprisingly, the Berwick review[17] charged with distilling the lessons to be learnt from events at Mid Staffordshire, endorses this consensus in its decalogue of recommendations: "Transparency should be complete, timely and unequivocal."

To illustrate the explosion of information, consider the NHS Choices website and the information it offers about local hospitals: user ratings, the proportion of staff who would recommend

their organisation, responsiveness to patient safety alerts, mortality rates, Care Quality Commission ratings, and "friends and family" test scores. The mortality rates of individual consultants in a range of surgical specialties can also be inspected. Or consider the information presented about each hospital under review in the Keogh report. This included the number of "never events," the readings of the "safety thermometer," the ombudsman's ratings, clinical negligence payments, the incidence of pressure ulcers, the number of harm incidents reported, consultant appraisal rates, sickness absence rates. The list could go on.

Exposure of the NHS's activities on this scale would have been inconceivable even a decade ago. But it may be that the rhetorical claims made on behalf of transparency need qualification. How are would-be consumers to interpret mortality rates when the vexed question of their relation with avoidable deaths remains to be resolved?[18] What weight should they give to the newly introduced friends and family test score—enthusiastically hailed by the prime minister as "a single measure that looks at the quality of care across the country"—when the results are based on an England-wide response rate of 13.1%?[19] More information may complicate rather than enhance the ability of consumers to make choices because they have to cope with an ever growing menu of indicators, varying in quality and sometimes pointing in different directions.

Not only has there been an explosion of information over recent decades. But a succession of agencies, regulators, and inspectorates have been set up to ensure patient safety and to promote quality. Yet still the dribble of revelations about poor, sometimes scandalously so, care continues. There is a paradox here. Transparency and surveillance may help to drive up overall NHS standards. But the more every aspect of NHS activity is unveiled, the more likely is the revelation of the occasional inadequacy or worse, which is inevitable in a service as large and complex as the NHS. No system of surveillance can guard against that, though it may encourage the belief that absolute safety and immaculate standards can be guaranteed, so compounding disillusionment with the NHS when it becomes apparent that this is not so. Given the asymmetry of media attention, it is the inadequate that will command the headlines and help to shape perceptions of, and trust in, the NHS. Transparency thus has its costs as well as its benefits. And those costs may increase in the hard times ahead when bad news may well outweigh the good.

New agenda

Austerity will inevitably create a new agenda with its own rhetoric. And it will require a new kind of "tough" choice: decisions not about how best to maximise benefits but about how to minimise harms. Take the example of privately funded healthcare. This may well expand, after a period of stagnation, in response to lengthening waiting times, as clinical commissioning groups restrict referrals by raising thresholds, among other rationing strategies.[20] Inevitably, this will prompt indignation about the (indisputable) social inequities of a two tier healthcare system. But, of course, there has been a two tier healthcare system in the UK ever since 1948, when Aneurin Bevan conceded the right to private practice as the price of overcoming medical resistance to the creation of the NHS: pragmatism trumped principle. Similarly, there may be a pragmatic argument now for diverting demand for elective surgery to the private sector for those who can afford to pay, if this helps the NHS to protect services for older people and those with long term conditions who cannot afford to pay. Other issues, such as raising more income for the NHS through charges, may prompt even more uncomfortable questions. Should policies that are undesirable in themselves be accepted as a price of safeguarding the core of the NHS? How is that core to be defined? What are acceptable lesser evils?

The age of austerity is, of course, itself the product of rhetoric. It is the rhetoric of a model that sees salvation in balanced budgets and reduced public borrowing and results in the reality of economic stagnation and cuts in public spending. This hairshirt approach has been challenged by many, Nobel prize winning economists among them. And the best hope for the NHS is that the challenge will succeed before too many irreversible lesser evils have been found acceptable.

Rudolf Klein emeritus professor of social policy, University of Bath, Bath, UK
rudolfklein30@gmail.com

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