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How NHS reform goes round in circles

John Oldham examines why repeated reforms of the NHS have failed to deliver changes in the daily experience of patients, particularly those with multimorbidity

The NHS in England has undergone structural reform more times than I have changed my mobile phone. The driver is almost always political, with the government, of whichever party, reacting to public frustrations with the health and care system. These frustrations express themselves both publicly in the media and more privately in the constituency surgeries of members of parliament. Concerns often reflect the poor experience of patients, but occasionally point to substantial failures of care.¹

Secretaries of state come to office determined to use the levers of power to tackle the problems. The last few secretaries of state have all correctly analysed the NHS as lacking a patient centric approach and needing deep reform. The wind of change follows, at least for the tenure of the secretary of state (average 26 months), but the tendency is for the centre of gravity soon to re-establish itself, making the NHS resistant to fundamental change, slow to adopt innovation, slow to learn from good practice both inside the NHS and elsewhere, slow to implement what works, and slow to respond to societal shifts (figure).

Such structural reforms, by and large, have not transformed the day to day experience of patients. We need to understand why that is and what creates the centre of gravity that is so resistant to real improvement. I believe this is because there are fundamentals within the healthcare system that remain untouched.

System built on body parts

The disease burden and the requirements of patients in 2013 are very different from those of patients in 1948. Broadly, the main challenge in 1948 was infectious disease; now it is long term conditions. Yet a doctor or nurse of 1948 walking into a hospital or general practice today would find more points of familiarity in the way they are organised, than not.

People with long term conditions now account for 70% of cost and activity in the healthcare system.² Most people over 65 have more than one long term condition, yet the system is one of specialisms that look after a person's body parts



The reform cycle

not the person as a whole. There is a mismatch between the needs of the patients driving the system and the operational configuration in place to meet that demand.

This operational dissonance is entrenched from policy generation to delivery point. For example, in the medical directorate of NHS England there is the seemingly illogical position of 18 national clinical directors of "body parts," principally from a secondary care medical background. Each creates a strategy, often involving colleagues with similar specialised interests. Primary care, community services, and allied professionals are minority players in policy creation, contrasting with the percentage of activity they undertake in the NHS. Therefore, from the top of the structure, there is a distorted weight to priorities and policy generation that, for example, at the front line, led to the equivalent of a Monty Pythonesque queue of specialist nurses for single diseases outside the house of a patient with multimorbidity,

What patients require is multidisciplinary, coordinated, socio-medical care that is primarily community based—a pooling of expertise. Such team based multidisciplinary mechanisms are known to be effective in determining priorities and action when faced with competing and complex requirements. Many clinicians are not trained to develop such skills. The training structure of professionals remains largely unprofessional and specific, narrowing with career time. Forcing the front line to look at very specific issues separates individual professionals from each other and ill equips them to deal with the complex patients of 2013. Skills in multidisciplinary

teamwork, in developing a generalist as well as a specialist perspective, and in working across organisational boundaries are required. The absence of such characteristics leads to individuals working how they have always worked, and how the people before them have worked. The 65 year long culture of "it's the way we do things around here" is entrenched. The configuration at the top of the NHS reinforces this culture and real fundamental change can be seen off.

Harm from competing demands

Policy generating mechanisms unwittingly conspire to create a scenario of competing, and sometimes conflicting, demands on the NHS, at both the financial/managerial and the clinical level. Each reform brings a new set of changed demands. Competing demands on individuals leads to suboptimisation of both their sole and their collective performance, and to an acceptance of mediocrity as the norm, since good cannot be achieved.³ Trying harder doesn't work because different and opposing parts of the system prevent overall improvement.

In finance, the drivers, both regulatory and with payment by results, encourage predominantly episodic care. Community service contracts are often opaque. None of the financial flows and commissioning mechanisms truly has a population view. The policy and senior managerial requirement is to move the system towards longitudinal, proactive, holistic, and community biased care, but the financial system and incentives

drive in the opposite direction. Frontline staff are at the sharp end of that inconsistency and this may affect their performance as well as their health economies.

Clinical staff, arguably, face ever more competing demands. Creating 107 quality standards (the task for the National Institute for Health and Care Excellence) is heralded as a talisman of safety virility. In reality it is a harbinger of quality impotence. As more standards are created (and

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lobbied for by special interests), fewer can be implemented or are relevant to the multimorbid patient population. For example, following the guidelines for control of hypertension may worsen someone's coexisting renal disease. Only 19% of patients with chronic obstructive pulmonary disease have no comorbidities. Nevertheless, quality standards and guidelines for this condition are configured as if the disease is the only one that needs considering. Applying multiple guidelines and standards to a person with multiple problems misses the point and creates clinical variance and uncertainty.

Bias to status quo

There are substantial stakeholders in the healthcare system whose power and prestige is secured if things don't change very much. Sometimes, this results in overt protection of their sectional interest (often wrapped in the flag of defence of the NHS), albeit with a genuine belief that there is a need to protect the system as they see it.

The civil service, for example, contains hard working, bright, and committed people. Their task is to translate ministerial requirement into policy action, and they do so with integrity. They also have their own strategic perception about how to keep the healthcare system funded, functional, and safe. Sometimes both ministerial requirement and civil service strategic perception are in alignment, and movement occurs. Other times they are not. The tension tends to preserve the fundamentals of healthcare delivery and encourage a focus on organisational structural change.

The academic colleges have had a huge, positive effect on quality and standards, but they also exhibit their heritage of trade associations (guilds) protecting their members. The reality of having 28 medical colleges, all but one secondary care oriented, requires each to have a distinctive presence and voice to further the wishes of their constituents within the policy generating mechanism. This volume of input tends to overwhelm that of the other professions and primary and community care, which in turn reinforces status quo. The separation of colleges also ensures separation in professional training. This entrenches fragmentation within the fabric of the healthcare system.

Death by research

Advancement in careers in many branches of medicine requires curriculum vitae to show publication of research papers. Much of this research

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could be argued to be duplicative, relatively non-contributory, and focused on a particular micro-section of medicine. However, a culture of research also creates a belief that evidence is what delivers improvement. It does not. There are 850 000 peer reviewed health related papers published annually, globally. It is not just the volume that is confusing; much of the evidence is flawed, and some even plain wrong.^{4 5} Yet clinicians do not move without evidence.

When there is agreement about what needs to happen it is speedy implementation that is the problem. Of course, implementation requires evidence, but it also requires an understanding of systems, processes, and human factors, and how to link them.⁶ For example, hand washing in between patients is not a new technology and the evidence is clear—but it didn't happen without substantial system effort amending individual human behaviour. Similarly, the engagement and involvement process that created the NHS plan, under Alan Milburn, made a determined effort to create a frontline movement for change and led to some success in reducing waiting times and improving quality in, for example, cancer and cardiac services.⁷ In this case there was systematic engagement with professional and managerial staff to debate the "how." The stated goals were a given, but the details were created by a tightly timed process of multidisciplinary working groups delivering recommendations.

The culture of evidence (as opposed to implementation) has other effects. The adoption of techniques shown to work elsewhere is often subjected to a desire to reprove the evidence first. This may also be used effectively to delay implementation of something that challenges a traditional way of working. The sector driven research process is reflected in the publications, which in turn ensure a weighting around specific diseases and conditions. This bias carries over when NICE and others search for evidence to inform guidelines and quality standards. The resulting guidelines and standards can take the system in the opposite direction from that which it needs, dealing with the absolutes of specific diseases (the minority of patients) not the compromises in comorbidity

(the majority). This is not to deny that research is vital. A search for the literature on managing people with comorbidity shows where the gaps lie.

More effective reform: "physiology, not anatomy"

My basic tenet is that few reforms have truly transformed the delivery of healthcare as it is experienced by patients in the NHS in England. They have often been the wrong sort of reform—focused on organisational structure not the way organisations work or what drives organisations to work that way—and do not reflect the multimorbid complex needs of most patients. Fundamental elements of the healthcare system not only remain untouched by reforms but create a self regenerative cycle that impedes true transformation. Although I have focused on the NHS, similar problems can be seen in the health systems of many other countries.

The next iteration of reform must not focus on structures but begin the rebalancing needed: rewarding longitudinal population care, prioritising and narrowing the focus of system-wide demands, creating equivalent generalist and multidisciplinary input to policy generation, and placing as much emphasis and reward on implementation as there is on research, in both training and career advancement.

Most importantly, the health and social care system experienced by citizens will be bettered by a deeper understanding of the nature and holistic needs of the patients and users that are the main drivers of activity. Professions and organisations should reform their functioning around those whole people, and not around body parts. Multimorbidity and complex patients and their needs are the new frontier of healthcare.

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