Funding the Future

Has everything changed in the NHS?

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I have spent several hours discussing the NHS this weekend with someone who has known it quite well for more than a quarter of a century - my wife. She is a GP but spent rather longer than most in that part of the medical profession working as a hospital doctor before shifting direction. Hardly surprisingly she has an opinion on what is going in in the NHS as a result, as do I. Our conclusion was that everything is changing in the NHS, for a number of reasons, although we each reached that conclusion for differing reasons.

Her conclusion is that of greatest significance is the change in mood of the one of Colleges of which she is a member, the Royal College of General Practitioners. Until very recently that College appeared to accept that whatever happened with regard to resources GPs could and should supply an ideal service to all in the UK. But that now seems to have changed: the RCGP no longer seems to think that is the case. They now seem to have shrugged their shoulders in resignation and have accepted that the ideal GP service, let alone the ideal GP consultation is not possible for three reasons.

The first is that government pressure has made it impossible. A decade or so ago they changed the way that GPs were rewarded and introduced the Quality and Outcomes Framework (QOF) scheme to reward GPs. This required vast amounts of form filling, but also dramatically increased the focus on some aspects of preventative medicine for which the evidence bases were not always very strong e.g. (I'm told) chronic kidney disease. The result was that if GPs would be paid then they had to undertake considerable numbers of tests, invite patients back for repeat monitoring, and use very large numbers of appointments in the process. Given that money was attached to these outcomes, hardly surprisingly that's what GPs did. All of this was predicated upon resources being available, and whilst they were it worked. And now those resources aren't available. But GPs still have to do the repeat preventative appointments or they lose income - which means they lose staff now, because their budgets are already cut, and so the resources available for those who are really ill are being cut dramatically. The basis on which the system was designed does not work, and it's now a serious impediment to progress in itself.

Second, the ideal GP consultation takes 12 minutes, at least. Once it was possible to aspire to that. Now it is not. There are too many appointments to make that possible. So GPs have given up hope of doing things well. The best they can now do is as well as possible, which is not the same thing at all. It's not their fault: it's a recognition of what is possible now.

Third, GPs have under the Health and Social Care framework been set in opposition to hospitals. The crisis at Hinchingbrooke reveals that: when Circle thought it was going to run a surplus by dragging resources from primary care GP on the Clinical Commissioning Group dragged those resources back. It does not really matter who is right or wrong: the system is wrong, and that's the point. GPs without management skills are being asked to run a service as well as their own practices and conflicts are built into the system which is designed to be competitive and not co-operative and the outcome is inevitable: all competition is predicated on the idea that failure is not just possible but desirable and failure is what we get as a result. But the cost of failure in this case is real human suffering.

I'd look at this a bit differently although none the less reaching the same conclusion. First, I'd suggest all systems require the maintenance of a necessary minimum number of systems including back ups and alternatives to ensure that failure can always be accommodated, and failure is inevitable in any human system. After a number of years of pressure for cuts those alternatives have been deemed wasteful and have been eliminated. The result is that the capacity to manage crisis no longer exists. A crisis is not now about making decisions on which alternative resources to use: it is about saying there are not alternatives. All of which proves the absurdity of the drive for productivity in the NHS and many other public services. In many markets inability to supply results in either price change or substitution of products. In essential services inability to supply results in real hardship. Cutting the resources to the minimum needed to maintain regular supply is not wise in that case. In fact it's the exact opposite: it's about guaranteeing failure to meet peek demand, and that is what is happening now in the NHS because a market language where failure can occur has, again, been applied to a public service where failure to supply is unacceptable.

Second, there's been an extraordinary change in the public. The logic of health markets was that the public could make choices and exercise informed judgement. In fact we have seen them do nothing of the sort. Over recent years the public has changed dramatically, which is the other major reason for increased appointment demand. Far from exercising judgement, the public now demands that it has a right to be 'put right now'. They do not respect the fact that not all medical issues are soluble. Nor do they realise, as they once did, that many more issues are solved in a few days simply with the passage of time. So we get the increasing demand, frequently heard at doctor's reception desks, that an appointment is needed today and not three days time because "I'll be better by then". Precisely. The health market has not encouraged choice or judgement. It seems to have created total dependence where people wish to accept no

responsibility for themselves. Deeply unpopular triage systems are the consequence - where those who have no need to see a doctor whether in A&E or at a GPs have to be weeded from the system to allow room for those with real need have to be introduced. That's not fun for anyone, but social change requires it.

And third, there is a failure to recognise that if this is what people want then they have to be supplied with it - and be charged the tax that pays for it. People are making choices: politicians would be wise to follow their demand, increase spending, increase tax and keep people happy.

But in the meantime it is inevitable that health systems need re-design, again. A focus on putting most of the world on a statin looks like an unaffordable luxury now. And GPs need to be paid to meet need, not want. Whilst hospitals have to learn how to send the worried well way in the shortest possible time. And all of that has to happen in a system where co-ordination has to be come the vital management watchword, which means the whole disintegration of regional health authorities and primary and secondary care into competing units has to be reversed.

The idea of re-organising the NHS seems deeply unpalatable but Lansley's disastrous legacy, for which he has already been consigned to the wilderness, cannot survive. The NHS has to become national, again. And it has to ensure all current health needs are met as a priority. And service has to be at its core - and that does not leave room for profit.

Hinchingbrooke's failure is not chance: it was inevitable. Preventing more failure is now what is needed. But it will take a big new vision, not tinkering at the edges. And that will mean that a great deal of change has to happen, soon. It's that or the NHS falls over. That's the choice we have.