Health reforms – are doctors onboard or overboard?

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This roadshow was held in Derby on 22 March 2007 and was organised by the Royal College of Physicians

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Introduction

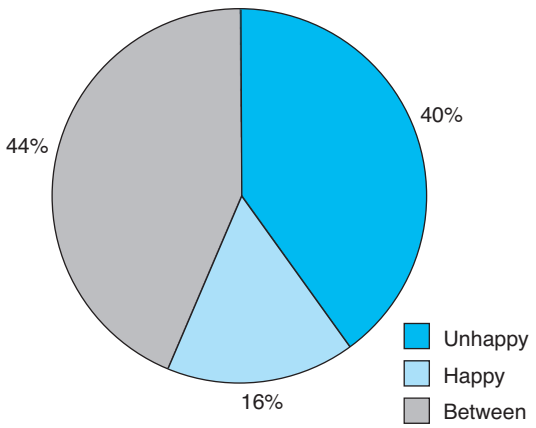
Nothing endures but change.
Heraclitus of Ephesus (535–475 BC)

The NHS has undergone constant change since its inception over sixty years ago. The past four years have seen three key and far-reaching policy changes from the Department of Health (DH):

- major restructuring of medical training in the form of Modernising Medical Careers (MMC)[1]
- changes in the funding of health provision in the form of Payment by Results (PbR)[2]
- a shift of healthcare provision from acute hospitals to other providers through the Care Closer to Home project.[3]

The health profession has been involved, notified and ignored to a varying degree with all of these changes. To assess physicians views on these developments the Royal College of Physicians (RCP) in collaboration with the DH set up a series of country-wide roadshows. The audiences were made up of consultant physicians, specialist registrars (SpRs) and general practitioners (GPs). Audience opinion was collected by several modalities including interactive keypad voting, roundtable and panel discussion. The following views were those raised at the first of these roadshows, held in the East Midlands and attended by eighty doctors.

Fig 1. How do you feel at the moment about the NHS?



Morale of the medical profession

The art in medicine consists in amusing the patient while nature cures the disease. Voltaire (1694–1778)

Many NHS consultants feel that politicians believe that the medical profession has not progressed since Voltaire's day and that doctors' views on improving patient care in the NHS are of little importance. Morale of doctors at all levels in the NHS is currently low, and only 16% of the audience at this meeting described themselves as 'happy' (Fig 1).

In their defence, the DH has recognised low morale in 2001 and introduced the Improving Working Lives (IWL) campaign to address this.[4] It seems many consultants, however, have little idea what IWL actually means. The new consultant contract, while resulting in many consultants being paid significantly more than they were three years ago, has not resulted in improved morale. Recent adverse press about the contract has also possibly reduced public support for hospital consultants. Doctors, however, remain the most trusted professionals according to a 2006 RCP poll. Ninety-two per cent of polled people 'trusted' doctors compared to politicians (20%) and journalists (19%).[5]

Modernising Medical Careers

TEKEL; Thou art weighed in the balances and art found wanting. Daniel 5:27

Modernising Medical Careers has arguably been the most divisive and disruptive change of the training structure in the modern history of the NHS. Initially intended to improve the training of senior house officers,[6] it has been expanded to involve SpR training resulting in the creation of run-through grade training.

There has been uproar from the medical profession over the past few months as MMC has lurched forward. On the day of the conference, for example, the newspaper headlines were dominated by a London march arranged by the pressure group RemedyUK in protest against MMC and the Medical Training Application Service (MTAS).

The repercussions of MMC have yet to be fully realised and, as this report is written, the situation continues to change daily. Since the conference, RemedyUK has lost a High Court case testing the

legality of MTAS, a review group has been set up (the membership of which has steadily dwindled), key personnel have resigned (including the BMA chair and MMC leaders) and an independent review has been established. Throughout all of this, the DH has remained consistent in its' belief in MMC.

It remains to be seen whether mass medical unemployment will occur as some have feared, and there have already been attempts to apportion blame within the profession as to how MMC was allowed to happen. Many feel MMC epitomises the distance between the medical profession and the DH, and the loss of statutory control of physician training from the RCP to the Postgraduate Medical Education and Training Board effectively removed any hope that the RCP could change the course of MMC. History will record who is the Belshazzar of MMC, but the 'writing was on the wall' in the early DH documents and the profession will surely have to shoulder some responsibility.

Payment by Results

It is the quality of lending over the quantity.

Lewis Thomas Preston (1926–95)

Payment by Results was introduced to focus on improved quality of healthcare and to make funding open and transparent. All healthcare providers are paid the same for a particular operation or treatment and so because of patient choice, quality of care should improve. It should also result in improved efficiency as providers attempt to deliver more treatments and boost profits. Waiting times, hospital stays, and referrals from primary care trusts (PCTs) (as PCTs attempt to reduce costs) should all be reduced and the recording of healthcare activity should improve. It is envisaged that PbR will account for 90% of hospitals' incomes, higher than any other reimbursement system in the world.

In practice, however, 'Payment by Activity' has resulted, whereby the focus has shifted to easily costed, high-volume activities. Independent sector treatment centres (ISTCs) have been actively developed to undertake these procedures, removing this activity from acute trusts, while currently not showing any evidence of improved, or even equivalent, quality. Understandably, this has been seen by many as 'privatisation by the back door'.

There have been enormous problems with the NHS tariff, which was based on reference costs from two years previously. This has been particularly true for healthcare for patients with complex and chronic health problems where setting a tariff is virtually impossible. Acute hospitals have traditionally offset the costs of managing these conditions by the activity from predictable high-volume procedures. The advent of ISTCs has thus threatened the entire stability of many trusts. Problems with the tariff are a major cause for most trusts currently being in debt.

Many consultants, however, agree that savings need to be made and indeed that healthcare should be rationed (Figs 2 and 3). The National Institute for Health and Clinical Excellence (NICE) is one way by which rationing (or more palatably 'improving cost-effectiveness') can be introduced into healthcare. Most consultants at this meeting were keen to see NICE have more autonomy and control over healthcare delivery, but it was also acknowledged that consultants are often the first to complain when services are reconfigured.

Fig 2. Will there ever be enough money to provide excellent and equitable healthcare to everyone?

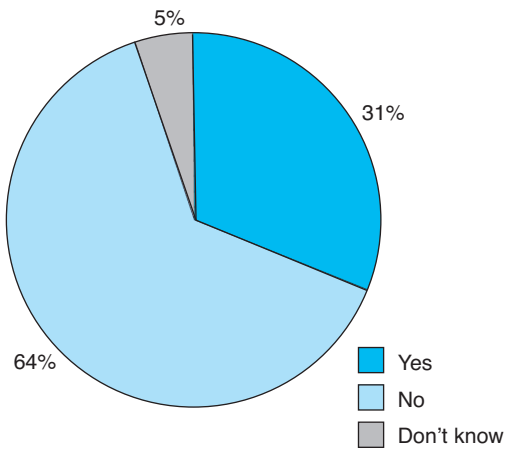
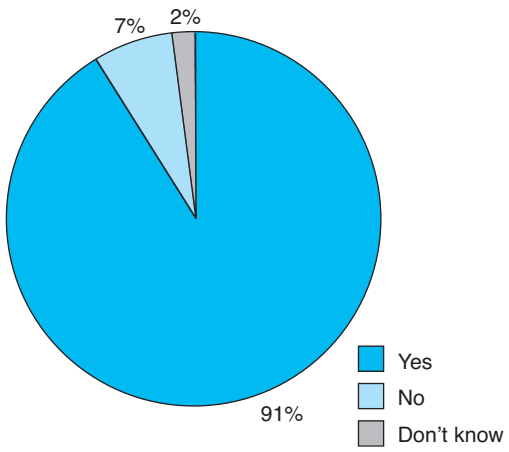


Fig 3. Will a publicly funded health service always need rationing?



Care Closer to Home

It is vain to talk of the interest of the community, without understanding what is the interest of the individual.

Jeremy Bentham (1748–1832)

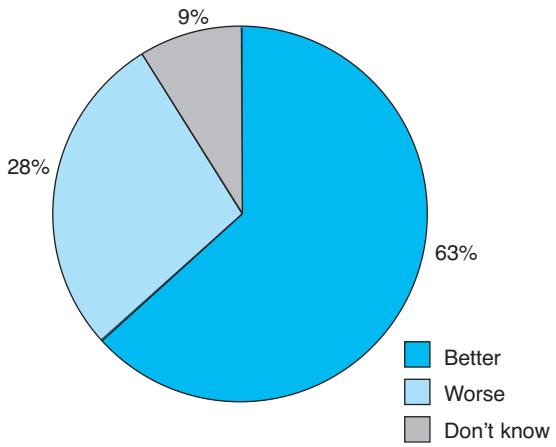
The White Paper entitled *Our health, our care, our say: a new direction for community services* set out the case for health service reform. It was based on a consultation involving 140,000 people, the key findings of which were:

- a substantial increase in the public expectations about healthcare
- the need for services to be more responsive to the needs of individuals and communities
- the need for clear national and local leadership of healthcare services.

The White Paper makes it clear that 'innovative providers' will be encouraged in order to move services out into the community. Such providers may be entrepreneurial GPs, cooperatives and ISTCs. It seems likely that GPs with special interests will increase in number, although there are concerns about the training and continual professional development of such individuals. It is also clear that healthcare providers and PCTs will need to provide more information on their services including performance, results of patient surveys, and accessibility.

There is considerable concern among some specialties (for example dermatology, rheumatology and diabetology) about the effect these changes will have on specialists and the standard of patient care.

Fig 4. Are things getting better or worse?



Conclusion

The NHS is changing beyond recognition and will continue to do so over the next few years. Interestingly, many physicians believe these changes are for the better (Fig 4), but they do not feel in control. Doctors and politicians will always make uncomfortable bedfellows, but they must learn to work together and compromise to improve health services. If we learn nothing else from the MMC debacle, it is this.

Conflict of interest

The author is a consultant physician in a busy acute trust and an RCP College Tutor.

Further information

For further details of the health reform debate please go to www.rcplondon.ac.uk/news/healthreform/index.asp

References

1 Department of Health. *Modernising medical careers: the response of the four UK Health Ministers to the consultation on 'Unfinished business – proposals for reform of the senior house officer grade'*. London: DH, 2003.
2 Department of Health. *Payment by Results: preparing for 2005*. London: DH, 2003.
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4 Department of Health. *Review body on doctors' and dentists' remuneration – review for 2003: written evidence from the health departments for Great Britain*. London: DH, 2003.
5 'Doctors top the polls as the professionals the public trust most'. www.rcplondon.ac.uk/news/news.asp?PR_id=330
6 Department of Health. *Unfinished business: proposals for reform of the senior house officer grade – a paper for consultation*. London: DH, 2002.