



## Modernisation or reform? The NHS approach

*The modernisation agenda is a valiant attempt to move forwards, but is it real change and will it make a difference?*

AS AUSTRALIA REFLECTS on healthcare directions after a quarter of a century of Medicare, what has the UK done to update its rather older National Health Service (NHS)? In 2000, the “NHS Plan” ([www.nhs.uk/nationalplan/](http://www.nhs.uk/nationalplan/)) set out an ambitious attempt at modernisation — “to give the people of Britain a health service fit for the 21st century”. It promised record investment and a number of defined dividends for that investment, such as extra hospital beds and more nurses and doctors. Modernisation became the catchword. A Modernisation Board was convened to oversee the process, a Modernisation Agency created to spread good practice, and a number of other organisations established. These include the National Institute for Clinical Excellence, which reviews drugs, new technology and procedures and then issues guidelines; and the Commission for Health Improvement (already re-engineered once), an independent inspection body that publishes reports, including performance ratings.

The whole scope of the NHS reorganisation that has followed is not worth reporting in detail here, for, by the time this *Postcard* appears, it is likely that further reorganisation may have been put in place. But what does the government really mean by “modernisation”? Is it a fundamental shift or just words? Are there lessons for Australia and Medicare?

The Modernisation Agency ([www.modern.nhs.uk](http://www.modern.nhs.uk)) has its sights on a number of areas: primary care, secondary (hospital) care, mental health services, leadership and workforce, clinical governance, innovation and improvement, and good practice. “3 Rs” have been coined — renewal, redesign, respect — and “5 simple rules” laid down:

- see things through the patient’s eyes;
- find a better way of doing things;
- look at the whole picture;
- give frontline staff the time and the tools to tackle the problems; and
- take small steps as well as big leaps.

There is an obvious abundance of rhetoric, but is there any substance?

One example in the primary care arena is coronary heart disease (CHD): 30 CHD Collaboratives have been established across England to improve cardiac services by bringing together professionals working in primary care and their hospital-based cardiological colleagues. Although these Collaboratives aim “to fundamentally redesign the systems for prevention, diagnosis, treatment and care of CHD”, what has actually been instituted (accompanied by fanatical fervour and exaggerated claims about its value) is a quality-improvement exercise that is difficult to generalise and impossible to evaluate.

There is an expectation that modernisation initiatives should be evaluated, and the Modernisation Agency has espoused a commitment to “quick and clean” research to

capture and share the learning gained through service improvement activities. Despite this commitment, the resources needed for adequate evaluation of modernisation projects are rarely set aside, and only occasionally are academics who are trained and experienced in evaluation of health services brought into the picture. Simultaneously, closure of the excellent NHS Research and Development Programme, established under a previous Conservative government, has seriously curtailed much of the investigator-initiated health services research. Instead, concerns about the slowness and “relevance” of academic enquiry have seen the ascendancy of change for the sake of being seen to be doing something within the NHS. In a world reminiscent of a kind of Maoist “continuous revolution”, an evaluation report, no matter what its quality, *does* become irrelevant if things have already changed again before the assessment of the earlier initiative is complete.

Since the Modernisation Agency was established, Foundation Trusts have arrived on the scene. Those achieving Foundation status are allowed to set their own salary scales and to raise their own capital. The Bill to create them had a rough ride in the UK Parliament and only just survived. We don’t really know yet what Foundation Trusts will achieve, but, presumably, they are a further step towards encouraging private investment in the NHS. We have recently been told that “targets” (benchmarks of performance used as a management tool leading to the awarding of Michelin-like “star” ratings to individual Trusts) are out — they are not popular, nor usually evidence based. So, it’s change again — but is it real change and will it make a difference?

Pieter Degeling and colleagues<sup>1</sup> have attempted to cut through the rhetoric and suggested that the modernisation agenda requires healthcare workers and managers to accept loss of clinical autonomy. They need to share power through team-based approaches to dealing with the resource implications of clinical activity. These authors find that the top-down method of performance management is not appreciated — and that this displeasure is shared by clinicians not only in the UK but across continents. The change in work practices of clinicians is, of course, only part of the UK modernisation agenda, but it is fundamental to it.

By contrast, “modernisation” in Australian healthcare has progressed through incremental change, which can be more sustainable. It needs to take into account Australia’s complex structures, fragmentation of providers and the idiosyncrasies of the State–Commonwealth divide. Yet, there is probably a stronger recognition of the need for incentives — to motivate clinicians, and to avoid heavy-handed, top-down approaches that can leave a workforce feeling demoralised and out of step. Despite its rather eccentric structure, the

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healthcare system in Australia manages to produce good outcomes.

Surveys reveal reasonable levels of satisfaction with the healthcare system among workers and patients in Australia, and among the British public there are high levels of commitment to the NHS. However, the morale of the health workforce in the UK is extremely low. If the sceptics among the readers of this *Postcard* don't believe there is a difference, come and work in the UK!

The good news about the NHS modernisation agenda is that it exists, and is a valiant attempt to move forwards. It is, however, imposed from above, full of rhetoric, short on substance and poorly evaluated. It does not deal with the fundamental problems of the NHS — decades of infrastruc-

ture neglect, low staff-to-population ratios, chronic overload, and a focus on process rather than outcome.

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1. Degeling P, Maxwell S, Kennedy J, Coyle B. Medicine, management, and modernisation: a "danse macabre"? *BMJ* 2003; 326: 649-652. □