What drives the NHS?

THE UK'S NATIONAL HEALTH SERVICE ("the NHS"), with 1.3 million employees, has now become the world's second largest employer after the army of the People's Republic of China. How can anyone drive anything that large? The former UK Secretary of State for Health, Alan Milburn, tried doing it for 6 years and, within days of his resignation, was instead defending tobacco industry jobs in his own constituency. At least he wasn't driven to drink; to us, as newcomers to the United Kingdom trying to make sense of this unwieldy bureaucracy while surviving the deep midwinter, a drink looks pretty good.

A relic of the Milburn era is a profusion of performance targets, not only for hospitals, but for general practice and primary care as well. Someone has reckoned that across the NHS there are at least 1200 targets. A basket of 34 of them determines whether hospitals and Primary Care Trusts attract no, one, two or three stars — the NHS equivalent of Michelin ratings. These are important drivers, because the star rating determines access to funds — those who do well are rewarded with more public money to do even better; laggards are left to limp along: *"The fault, dear Brutus, is not in our stars, but in ourselves, that we are underlings"*.

A great many of the targets relate to the processes of health care and precious few to its outcomes. Waiting lists for elective surgery, and "trolley waits" in accident and emergency departments are part of public discussion in the UK now, while particular institutions are lambasted for poor medical records or general cleanliness. The focus on targets reflects a belief in the benefits of centralisation and a lack of trust in those at the coalface. This has led to demoralised health professionals. Furthermore, the emphasis on process rather than outcome is partly due to a perception that the public is unable to understand more than waiting times.

The UK lacks the health consumerism of Australia; while the NHS remains part of the social fabric, there are often low public expectations, and medical issues remain mysterious to most people. The public-health community is driven by a health inequalities agenda, which is remote enough from service delivery to make it irrelevant to the health service. Thus, there is no one to help set priorities to improve public health and prevent the agenda being driven by how care is delivered rather than by what it achieves. While the system is awash with forms and information, it is totally unable to link records. It took long enough to recognise the excess short-term mortality in the paediatric cardiac surgical service in Bristol; there is no hope of routinely measuring clinically important long-term outcomes.

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Meanwhile, targets are responsible for distorting NHS activity on a day-to-day basis. Hospitals shift their staff around to reduce "trolley waits" during the week when the inspectors from the Commission for Health Improvement are visiting, and accusations of waiting-list fiddling are heard regularly. More profoundly, the orientation of many people in the middle layers of the NHS has undergone an about-face. Instead of attending to problems reported from below about barriers to delivering high-quality care in a timely fashion, the focus of most middle managers is on meeting targets imposed from above, from levels even more remote from the delivery of service.

In the early days of the NHS, there is no doubt that doctors called the shots. This lasted for several decades, until the development of Thatcher's internal market (consisting of large numbers of "business units", each of which needed a manager); the focus on targets and performance; and, most recently, the clinical governance agenda. Oddly, both doctors and managers feel disempowered and believe that someone else is in charge. So, are the managers themselves part of the problem (it's not the driver that's bad, but the transmission that's broken)? The Tory Party says that managers now outnumber beds in the NHS. Good clinicians from the whole spectrum of health professions have moved sideways into comfortable, well paid administrative roles that could be fulfilled during sociable hours, significantly depleting the ranks of those actually delivering healthcare and making the difficult clinical decisions that this involves.

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Konrad Jamrozik, *formerly, Professor of Public Health, University of Western Australia; currently, Professor of Primary Care Epidemiology, Imperial College of Charing Cross, London, UK.*

Richard Heller, *formerly, Professor of Community Medicine and Clinical Epidemiology, and Director of the Centre for Clinical Epidemiology and Biostatistics, University of Newcastle, Newcastle, Australia; currently, Professor of Public Health, University of Manchester, Manchester, UK.*

David Weller, *formerly, Senior Lecturer in General Practice, Flinders University, Adelaide, South Australia; currently, James Mackenzie Professor of General Practice, University of Edinburgh, Edinburgh, Scotland.*

you add up the wages and the travelling times, a single meeting can cost the same as a whole week of clinical care, but rarely will it take a decision that measurably affects anyone's health. Even when someone is brave enough to try a novel idea, managers further up the line are likely to impose a re-organisation long before enough time has passed to see if the new way is better. And that presupposes that adequate provision was made for a proper evaluation of the initiative, which is all too rarely the case. Not that people are unaware of the problem; the divide between management and the frontline underpins much of the current disaffection and malaise within the NHS. It's just that solutions to such complex problems don't come easily.[1] Some commentators become despondent, and suggest that the only effective strategy for managing a huge complex machine like the NHS is to muddle through.

Meanwhile, on the wards, in the outpatient clinics, and out in the practices, scores of dedicated health professionals and other staff struggle on. There are half the number of doctors per head of population compared with Australia, and the slice of gross domestic product dedicated to the NHS is at least a third less. One does not have to be driven, there is always someone waiting to be seen. Enjoy the sunshine this Christmas; your comrades over here may also be feeling the heat.

Konrad Jamrozik
Professor of Primary Care Epidemiology
Department of Primary Health Care and General Practice
Imperial College of Charing Cross, London, UK

Richard F Heller
Professor of Public Health
Evidence for Population Health Unit
School of Epidemiology and Health Sciences, School of Medicine
University of Manchester, Manchester, UK

David P Weller
Professor of General Practice
Division of Community Health Sciences
University of Edinburgh, Edinburgh, UK
k.jamrozik@imperial.ac.uk

1. Davies HTO, Harrison S. Trends in doctor-manager relationships. *BMJ* 2003; 326: 646-649. ❑