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A Transatlantic Review of the NHS at 60

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NHS Live: Wembley: 1 July 2008



Let me begin with thanks – twice. First, thanks for letting me work with you for almost 15 years; this has been one of the most satisfying journeys of my entire career. My colleagues in the Institute for Healthcare Improvement feel the same. Second, thanks for what the NHS does as an example for health care worldwide.

If you're a cynic, you'll want to go get a cup of tea about now. I am going to annoy you, because I am not a cynic. I am romantic about the NHS; I love it. All I need to do to rediscover the romance is to look at health care in my own country.

A towering bridge

The National Health Service is one of the truly astounding human endeavors of modern times. Just look at what you are trying to be: comprehensive, equitable, available to all, free at the point of care, and – more and more – aiming for excellence by world-class standards. And, because you have chosen to use a nation as the scale and taxation as the funding, the NHS isn't just technical – it's political. It is an arena where the tectonic plates of a society meet: technology, professionalism, macroeconomics, social diversity, and political ambition. It is a stage on which the polarizing debates of modern social theory play out: between market theorists and social planning, between enlightenment science and post-modern skeptics of science, between utilitarianism and individualism, between the premise that we are all responsible for each other and the premise that we are each responsible for ourselves, between those for whom government is a source of hope and those for whom government is hopeless. But, even in these debates, you have agreed hold in trust a commons. You are unified, movingly and most nobly, by your nation's promise to make good on an idea: the idea that health care is a human right. The NHS is a bridge – a towering bridge – between the rhetoric of justice and the fact of justice.

No one in their right mind would expect *that* to be easy. No one should wonder that, as the NHS celebrates its 60th birthday this week – an age at which humans recognize maturity, it seems still immature, adolescent, still searching.

You could have chosen an easier route. My nation did. It's easier in the United States because we do not promise health care as human right. Most of my countrymen think that's unrealistic. In America, they ask, "Who would assure such a right?" Here, you answer, "We do, through our government." In America, people ask, "How can health care be a human right? We can't afford it." We spend 17% of our Gross Domestic Product on health care – compared with your 9%. And, yet we have almost 50 million Americans, one in seven, who do not have health insurance. Here, you make it harder for yourselves, because you don't make that excuse. You cap your health care budget, and you make the political and economic choices you need to make to keep affordability within reach. And, you leave no one out.

Fragments

In the United States, our care is in fragments. Providers of care, whether for-profit or not-for-profit, are entrepreneurs. Each seeks to increase his share of the pie, at the expense of others. And so we don't have a rational structure of inter-related components; we have a collection of pieces – a caravan site. These disconnected, self-referential pieces cost us dearly. The entrepreneurial fragments create what the great health services researchers, Elliott Fisher and Jack Wennberg, call "supply-driven care." In America, the best predictor of cost is supply – the more we make, the more we use – hospital beds, consultancy services, procedures, diagnostic tests. Fisher and Wennberg find absolutely no relationship – none – between the supply and use, on the one hand, and the quality and outcomes of care, on the other hand. The least expensive fifth of hospital service areas in the US have *better* care and *better* outcomes than the most expensive fifth. Here, you choose a harder path. You plan the supply; you aim a bit low; historically, you prefer slightly too little of a technology or service to much too much; and then you search for care bottlenecks, and try to relieve them.

In the US, we favor specialty services and hospitals over primary care and community-based services. Americans are not guaranteed a medical home, as you are, and we face a serious shortage of primary care physicians. Hospitals, on the other hand, are abundant, with many communities vastly over-bedded – an invitation to supply-driven care. Coordinated care – care that keeps people from having to use hospitals – is rare; so are adequate home health care, hospice services, school-based clinics. Community social services and our mental health services are undefended, isolated, and insufficient. Public health and prevention are but stepchildren. Here, in the NHS, you have historically put primary care – general practice – where it belongs: at the forefront.

In the US, we can hold no one accountable for our problems. Accountability is as fragmented as care, itself; each, separate piece tries to craft excellence, but only within its own walls. Meanwhile, patients and carers wander among the fragments. No one manages their journey, and they are too often lost, forgotten, bewildered. Here, in England, accountability for the NHS is ultimately clear. Ultimately, the buck stops in the voting booth. You place the politicians between the public served and the people serving them. That is why Tony Blair commissioned new investment and modernization in the NHS when he took office, it is why government has repeatedly modified policies in a search for traction, and it is why your new government chartered the report by Lord Darzi. Government action on the NHS is not mere restlessness or recreation; it is accountability at work through the maddening, majestic machinery of politics.

In the United States, we fund health care through hundreds of insurance companies. Any American doctor or hospital interacts with a zoo of payment streams. Administrative costs for this zoo approach 20% of our total health care bill, at least three times as much as in England.

In the United States, those hundreds of insurance companies have a strong interest in *not* selling health insurance to people who are likely to need health care. Our insurance companies try to predict who will need care, and to find ways to exclude them from coverage through underwriting and selective marketing. That increases their profits. Here, you know that that isn't just crazy; it is immoral.

Equitable, civilized and humane

So, you could have had a simpler, less ambitious plan than the NHS. You could have had the American plan. You could have been spending 17% of your GDP and

made health care unaffordable as a human right instead of spending 9% and guaranteeing it as a human right. You could have kept your system in fragments and encouraged supply-driven demand, instead of making tough choices and planning your supply. You could have made hospitals and specialists, not general practice, your mainstay. You could have obscured – obliterated – accountability, or left it to the invisible hand of the market, instead of holding your politicians ultimately accountable for getting the NHS sorted. You could have let an unaccountable system play out in the darkness of private enterprise instead of accepting that a politically accountable system must act in the harsh and, admittedly, sometimes unfair, daylight of the press, public debate, and political campaigning. You could have a monstrous insurance industry of claims, rules, and paper-pushing, instead of using your tax base to provide a single route of finance. You could have protected the wealthy and the well, instead of recognizing that sick people tend to be poorer and that poor people tend to be sicker, and that any health care funding plan that is just, equitable, civilized, and humane must – *must* – redistribute wealth from the richer among us to the poorer and less fortunate.

Britain, you chose well. As troubled as you may believe the NHS to be, as uncertain its future, as controversial its plans, as negative its press, as contentious its politics, as beleaguered as it sometimes feels, please lift your eyes and behold the mess – the far bigger, costlier, unfair mess – that a less ambitious nation could have chosen.

Is the NHS perfect? Far, far from it. I know that as well as anyone in this room. From front line to Whitehall, I have had the privilege to observe its performance and even to help to measure it. The large scale facts are most recently summarized in the magisterial report by Sheila Leatherman and Kim Sutherland sponsored by The Nuffield Trust called *The Quest for Quality: Refining the NHS Reforms*. They find some good news. For example, after ten years of reinvestment and redesign, the NHS has more evidence-based care, lower mortality rates for major disease groups (especially cardiovascular diseases), lower waiting times for hospital, outpatient, and cancer care, more staff and technologies available, in some places better community-based mental health care, and falling rates of hospital infection. An important, large scale patient safety campaign has begun in England, as well as among your cousins in Wales, Scotland, and Northern Ireland. There is less progress in some areas, especially by comparison with other European systems, such as in specialty access, cancer outcomes, patient-centeredness, life expectancy and infant mortality for socially deprived populations. In other words, in improving its quality, two facts are true: the NHS is *en route*, and the NHS has a lot more work ahead.

How can you do even better? I have ten suggestions:

1. First, put the patient at the center – at the absolute center of your system of care. Put the patient at the center for *everything* that you do. In its most helpful and authentic form, this rule is bold; it is subversive. It feels very risky to both professionals and managers, especially at first. It is not focus groups or surveys or token representation. It is the active presence of patients, families, and communities in the design, management, assessment, and improvement of care, itself. It means customizing care literally to the level of the individual. It means asking, “How would you like this done?” It means equipping every patient for self-care as much as each wants. It means total transparency – broad daylight. It means that patients have their own medical records, and that restricted visiting hours are eliminated. It means, “Nothing about me without me.” It means that we who offer health care stop acting like hosts to patients and families, and start acting like guests in their lives. For professionals made anxious by this extreme image, let me simply remind you how you probably begin every encounter when you are following your best instincts; you ask, “How can I help you?” and then you fall silent and you listen.

2. Second, stop restructuring. In good faith and with sound logic, the leaders of the NHS and government have sorted and resorted local, regional, and national structures into a continual parade of new aggregates and agencies. Each change made sense, but the parade doesn’t make sense. It drains energy and confidence from the workforce and middle managers, who learn not to take risks, but rather to hold their breaths and wait for the next change. It is, I think, time to stop. No structure in a complex management system is ever perfect. There comes a time, and the time has come, for stability, on the basis of which, paradoxically, productive change becomes easier and faster, as the good, smart, committed people of the NHS – the one million wonderful people who can carry you into the future – find the confidence to try improvements without fearing the next earthquake.

3. Third, strengthen the local health care systems – community care systems – as a whole. What you call “health economies” should become the core of design: the core of leadership, management, inter-professional coordination, and goals for the NHS. This should be the natural unit of action for the Service, but it is as yet unrealized. The alternative, like in the US, is to have elements – hospitals, clinics, surgeries, and so on – but not a system of care. Our patients need integrated journeys; and they need us to tend and defend those journeys. I believe that the NHS has gone too far in the past decade toward optimizing hospital care – a fragment – and has not yet optimized the processes of care for communities. You can do that. It is, I think, your destiny.

4. Fourth, to help do that, reinvest in general practice and primary care. These, not hospital care, are the soul of a proper, community-oriented, health-preserving care system. General practice, not the hospital, is the jewel in the crown of the NHS. It always has been. Save it. Build it.

5. Fifth, please don’t put your faith in market forces. It’s a popular idea: that Adam Smith’s invisible hand would do a better job of designing care than leaders with plans can. I do not agree. I find little evidence anywhere that market forces, bluntly used, that is, consumer choice among an array of products with competitors’ fighting it out, leads to the health care system you want and need. In the US, competition has become toxic; it is a major reason for our duplicative, supply-driven, fragmented care system. Trust transparency; trust the wisdom of the informed public; but, do not trust market forces to give you the system you need. I favor total transparency, strong managerial skills, and accountability for improvement. I favor expanding choices. But, I cannot believe that the individual health care consumer can enforce through choice the proper configurations of a system as massive and complex as health care. That is for leaders to do.

6. Sixth, avoid supply-driven care like the plague. Unfettered growth and pursuit of institutional self-interest has been the engine of low value for the US health care system. It has made it unaffordable, and hasn’t helped patients at all.

7. Seventh, develop an integrated approach to the assessment, assurance, and improvement of quality. This is a major recommendation of Leatherman and Sutherland’s report, and I totally concur. England now has many governmental and quasi-governmental organizations concerned with assessing, assuring, and improving the performance of the NHS. But they do not work well with each other. The nation lacks a consistent, agreed map of roles and responsibilities that amount, in aggregate, to a coherent system of aim-setting, oversight, and assistance. Leatherman and Sutherland call this an “NHS National Quality Programme,” and it is one violation of my proposed rule against restructuring that I have no trouble endorsing.

8. Eighth, heal the divide among the professions, the managers, and the government. Since at least the mid-1980’s, a rift developed that has not yet healed between the professions of medicine formally organized and the reform projects of government and the executive. I assume there is plenty of blame to go around, and that the rift grew despite the best efforts of many leaders on both sides. But, the toll has been heavy: resistance, divided leadership, demoralization, confusion, frustration, excess economic costs, and occasional technical mistakes in the design of care. The NHS and the people it serves can ill afford another decade of misunderstanding and suspicion between the professions, on the one hand, and the managers and public servants, on the other hand. It is the duty of both to set it aside.

9. Ninth, train your health care workforce for the future, not the past. That workforce needs to master a whole new set of skills relevant to the leadership of and citizenship in the improvement of health care as a system – patient safety, continual improvement, teamwork, measurement, and patient-centered care, to name a few. Scotland announced last week that all its health professionals in training will master safety and quality improvement as part of their qualification. Far be it for me to suggest copying Scotland, but there you have it. I am pleased that Lord Darzi’s *Next Stage* report suggests such standards for the preparation of health care professionals in England.

10. Tenth, and finally, aim for health. I suppose your forebears could have called it the NHCS, the “National Health Care Service,” but they didn’t. They called it the “National Health Service.” Maybe they meant it. Maybe they meant to create an enterprise whose product – whose purpose – was not care, but health. Maybe they

knew then, as we surely know now, even before Sir Douglas Black and Sir Derek Wanless and Sir Michael Marmot, that great health care, technically delimited, cannot alone produce great health. Developed nations that forget that suffer the embarrassment of growing investments in health care with declining indices of health. The charismatic epidemics of SARS, mad cow, and influenza cannot hold a candle to the damage of the durable ones of obesity, violence, depression, substance abuse, and physical inactivity. Would it not be thrilling in the next decade for the NHS – the National *Health* Service – to live fully up to its middle name?

Those are my observations from far away – from an American fan, distant and stary-eyed about the glimpses I have had of your remarkable social project. The only sentiment that exceeds my admiration for the NHS is my hope for the NHS. I hope that you will never, never give up on what you have begun. I hope that you realize and reaffirm how badly you need, how badly the world needs, an example at scale of a health system that is universal, accessible, excellent, and free at the point of care – a health system that is, at its core, like the world we wish we had: generous, hopeful, confident, joyous, and just. Happy birthday!