NHS2.0: Beyond Beveridge: Emerging Threads

Introduction

On 28th February 2023 an invited group from, University College London Hospital, the Centre for Information Management, Loughborough University and the Cybernetics Society (see Attendees) with a shared interest in the challenge met at UCL Partners, London to explore the question:

If the Beveridge principles still hold, what would the NHS look like if we were creating it today?

The discussion was rooted in a brief provocation and reflection on three key pieces of work (see Sources of Inspiration). This document is developed from the contemporaneous notes taken during the discussion.

A Question of Purpose

It was suggested that the origins of the national health service addressed a very different population with very different needs for individuals and society and very different health capabilities to those which are encountered today.

Participants agreed that the Beveridge principles still hold but that they need re-interpreting to deliver a service that meets the contemporary context and the different inequalities persisting today compared with the 1940's. "Want, Disease, Ignorance, Squalor and Idleness" (Beveridge report, first source of inspiration) still exist but in different forms and to different extents than when the principles were written. Health services, only address some of these, and need to be considered and delivered in the context of wider governmental and societal services and schemes that address the other issues.

Briefly it seems that three moral/ethical/societal questions arise and must be addressed in conceptualising NHS2.0:

What is the purpose of the health service?

What is the responsibility of each individual for their own well-being?

How do we define 'healthcare' and manage its provision?

In the first of these questions there is a need for consideration of the understood and accepted purpose of health care provision. Whether the health service exists to 'fix sick people' or 'prevent illness' generates the boundary questions embedded which explore the limits to healthcare but which also need to recognise that there is, in practice, significant overlap – consultations can be both therapeutic and preventative. Over the 75 years of the NHS the ability to diagnose and treat illnesses in their many forms has led to significant gains in overall health yet, at the same time, it has brought into scope for treatment many illnesses and disorders which would have been

unrecognised or untreatable at the time of founding. Without a meaningful discussion about purpose we cannot properly discuss either limits or funding levels.

The second question is needed to consider a further boundary, that of personal responsibility. The challenge here is to consider the contribution of each individual to their own well-being and whether there is a limit to the responsibility of the state for each individual. The defining cases here will not be for those diseases or disorders which are prevalent, endemic, pandemic or genetic but those in which the individual might, at least in some cases, be considered to have agency such as are driven by substance abuse, smoking, alcohol use, lack of movement, gambling and so on. These are emotive topics but reasoning about them will expose the assumptions, challenges and, sometimes no doubt arbitrary, choices made around them by both patients and clinicians. This is a really complex area of debate. For example, people also have agency in the other preceding cases as was seen in COVID with people more or less sticking to lockdown rules in a pandemic situation. What is the state's responsibility then? From a medical perspective clinicians treat everyone according to need (at least in the UK), and unwise decisions have to be allowed on ethical grounds. This blurring of responsibility vs "undeserved" illness is also true of healthcare-seeking behaviours such that a disease may just happen, but early or late presentations of disease may be within an individual's control. Illnesses that may suggest more personal agency in their genesis such as diabetes mellitus due to obesity, on a closer look are more intertwined than this, as appetite set-points have a genetic component, may be influenced by eating habits, psychological states etc, and the diabetes may have a predisposing genetic component. As noted in Intelligent Nation (Beckford, 2021), resilient individuals are at the heart of a resilient society and nation but we need to address the challenges of resilience for each individual.

For the third question we must seek to define what falls inside the scope of healthcare and what elements, if any, would be more effectively or efficiently delivered through 'non-health' services such as families themselves, education, social care or through legislation governing provision of goods and services. Such clarity is important in being able to hold organisations and individuals accountable and for providing meaningful operational definitions of success or failure.

Each and all of these questions might also be legitimately applied to the provision of any public service. We need to be clear about the purpose of anything before we can understand how to establish its performance and necessary funding.

Effectiveness and Efficiency

Achieving clarity of purpose will enable us to give true meaning to the debate about the effectiveness and efficiency of healthcare services. Without such clarity any debate about these matters is moot.

> Effectiveness: a measure of the extent to which a desired outcome is achieved;
>
> Efficiency: measure of the yield on resources.

The latter can also be known as ‘productivity’ or ‘yield’ and considers the work done versus the resource provided; efficiency is a primary measure of short run performance, immediate value for money, but it tells us nothing of how the system as a whole is making a contribution.

We need first to understand what we want to achieve in terms of value and the operational definition of effectiveness to create context for the evaluation of cost and efficiency. However, healthcare provision is not simply a cost but is also an enabler of value. Through assisting people in being healthy, they are perhaps better able to work, or work till later in life and, in doing so they are able to contribute in both obvious and more hidden ways – not just employment but caring for family and others, volunteering etc.

To think about effectiveness and efficiency, we must then address the further moral/ethical/societal questions:

What is the contribution of the NHS to society?

What is the cost of the NHS to society?

What is the balance of value between them?

That is to say that there is no absolute means of setting a ‘budget’ for a healthcare service, it is not a mechanistic function of total GDP but a judgement based on the purposes we set for it. Is it the extent to which it keeps people well and living life to the full? Different groups and individuals will value health differently and we must account for that in our deliberations.

Leadership and Organisation

The NHS as it stands is widely perceived as bureaucratic, perhaps over-administered, perhaps under-managed. To some extent the ‘bureaucracy’ exists because the roles of leadership, governance and administration have not kept up with the pace of change in clinical capability and activity and, to some extent because investment in digital systems (for both patient care and organisational management) has fallen short both of what is required and of what is possible. In the latter regard it is not unlike many other publicly funded services. Contemporary technology applied intelligently would allow a transformation in management and the cost of the necessary bureaucracy both increasing effectiveness and reducing cost.

Organisationally, and notwithstanding examples of excellent practice, there can appear to be a disconnect between ‘doing’ and ‘managing,’ that is they are not seen as integrated functions of each other but are separated into clinical and administrative domains with the one attempting to provide the most appropriate clinical care (effectiveness) while the other pursues notions of productivity (efficiency), meanwhile clinical services are commonly fragmented in such a way that, beyond primary care, no one has responsibility for the ‘whole’ patient with complex or co-morbidity presentations being addressed through serial rather than parallel processing. Conflict between efficiency and effectiveness is institutionalised in the organising structures. Further compounding of this effect is found in both functional orientations and outsourced activities (e.g. commonly, duties

of porters in the first case, cleaning and catering in the second). These segregations mean that those accountable for clinical outcomes are not also accountable for, or able to direct the activity of, some of the resources required to facilitate those outcomes. Management of those resources, as experienced, is often seeking to control cost not maximise clinical gain.

Coupled to this, the 'enabling' functions (clinical diagnostics and therapeutics departments and clinical managerial support) that support clinical decision making are not, perhaps, aware that they are 'enabling' and attempt to be controlling or inhibitory. Enabling functions (Beckford, 2020, 2021) exist to support the delivery of care and should be established in a way that maximises the value derived from the scarcest and, often, most expensive resource whether that be people or equipment. For example, some elements of medical record keeping lend themselves to increased use of information systems, others will continue to rely on the nuanced skills of capable human beings. This provides benefits of efficiency, accuracy and humanity, automating high frequency, low clinical value tasks enabling an increase in throughput or additional clinical care.

Suggested next steps:

A clear focus on the fulfilment of the purpose of the healthcare system, addressing some of the issues raised above would enable a more informed discussion about the future of the NHS, not least it would inform a re-examination of the system of commissioning which is production rather than consumption led. Could a system where the money directly follows the patient (the clinical need), be more effective?

- Consider information flows – and the technology needed to support them;
- Participative design event to 'game the system:'
  - Walk through the way it works now, and the way it could work with different approaches and different answers to the core questions identified above;
- Align incentives:
  - Design incentives (extrinsic and intrinsic) to stimulate the clinical outcomes we seek to achieve;
- Explore, speculatively, alternative organisational processes and designs based around patient flows;
- Explore the potential gains from a radical reinvention of information flows to match patient flows.

Work is being undertaken that addresses a number of these points.

If you wish to comment on this paper or contribute to future work please contact John Beckford.

Attendees:

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Sources of Inspiration:

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References

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