

70 years of the NHS: the rise of patient choice

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The NHS has seen many changes since its inception in 1948, including developments around the philosophy of its management, how services are delivered and significant improvement in the quality of care provided. With people at the centre of its business model, there has always been an emphasis on prevention (rather than cure). Analysing healthcare needs on a population basis has amplified since 1948, through central policy, regulation, innovation and societal shifts.

DAC Beachcroft partners Corinne Slingso and Hamza Drabu, look back at the key moments in the rise of patient choice in healthcare throughout the NHS' 70 year history, and how the patient choice agenda continues to drive change in access to healthcare as we move through the 21st Century.

Paving the way for patients

The original ethos of the NHS was forged from a desire to create a system of healthcare accessible to all. Inevitably, it was created within a culture that mirrored society at the time, holding clinical professionals on pedestals whilst the public gained new access to time with doctors, with the wisdom of the clinician being followed by the less well informed patient.

The last 70 years has seen immeasurable change in society's socio-economic structures and, in turn, a change in perception of health professionals and their interaction with patients. In some healthcare settings, patients are now 'customers', and in regulatory terms they are now 'service users'; creating a language that reflects the absolute shift in importance of the patient.

Much of this shift has been policy based, but there have also been legal and regulatory 'moments' which have either rubber stamped or augmented that change. In 2006, 2008 and 2012, key steps in opening up patient choice occurred, resulting in a new freedom at the GP referral stage for the patient to decide where their secondary care would be received. This included Independent Sector Treatment Centres (both for capacity management and choice), local NHS providers and new entrants into the independent sector health market, where contracts with commissioners had been won. The market was firmly open for business on the competition side, but for the patient, these key changes created an ability to make decisions about their care, in circumstances where those decisions had, for over 50 years, been entirely driven by what the patient's GP decided. Choice was the reserve only of those patients with PMI or means to self-fund. A revolution was afoot.

The rise of choice

Whilst choice was opening up, there remained an absence of recognition as to what a patient could or should expect from the NHS, and what the NHS might expect in return. This issue was crystallised in January 2009, with the advent of the NHS Constitution, which sought to consolidate a number of different commitments from the NHS to their patients, including:

- Improved access to health services
- Quality of care and environment
- Nationally approved treatments, drugs and programmes
- Respect, consent and confidentiality
- Informed choice
- Involvement in your healthcare and in the NHS
- Complaint and redress focussing on high quality care

At the time, there was concern that the NHS Constitution would create a new stream of complaints and judicial reviews, in relation to decisions made by healthcare providers and commissioners, around specific cases and service reconfigurations. We recall training numerous NHS Boards on what the NHS Constitution meant, how it might be applied to services, and what it added to healthcare organisations in terms of responsibility and culture on patient engagement. We did see a small number of complaints which sought to reference elements of the NHS Constitution, and the occasional judicial review, but in reality the sector absorbed the NHS Constitution in the way it was intended - ie a simple statement of intent for health services and the patients who use them, to increase understanding between provider and patient, and to capture the increasing importance of patients at the centre of care.

With growing change through NHS Choices and the Constitution, it was inevitable that a need to provide a 'voice' for patients to develop greater self-determination in care pathways existed, as well as a need to provide 'ears' to listen to feedback on experiences within the rapidly expanding range of health services accessible to patients. Thus, the friends and

family test was born, initially as a vehicle through which providers and their commissioners could capture that feedback from patients and relatives. This has since evolved into a key metric against which providers are measured.

Amidst the healthcare revolution on patient choice and access, social care was no slouch - with the creation of personal budgets through which to take greater control of social care needs, the individual with those needs also became the decision-maker. This, against the 'nanny state' backdrop post WW2 which established these public sector services, remains one of the key moments in time.

But with choice comes responsibility. The Five Year Forward View, and policy position from NHS England, includes the personal accountability patients have for their own health, set within a population health approach (see below). The prevention rather than cure objective, against system-wide change and a new culture of individuals taking responsibility for leading healthier lives, will inevitably bite upon, for example, how personal health budgets evolve. There must be a quid pro quo for freedom and choice.

Medtech, access and choice

With the latest significant policy shifts in the NHS via the publication of the Five Year Forward View in 2014, there has been a substantive move towards a more 'population health' focused solution; where local health systems jointly plan the health and care needs of their population. A key component of this approach is to power it with the right data, underpinned by the right data sharing agreements. An example of which can be seen in the work of the Healthy London Partnership's Digital Programme; a programme that aims to create a broader interoperability framework across health and social care organisations within London. This sort of programme has the potential to breakdown the various data siloes that exist within the local organisations, each handling patient data in order to facilitate access to records for all organisations and, in time, patients themselves.

Alongside this integration of healthcare we are also seeing the implementation of medical technology that enables new care models to develop, including virtual appointments being offered to patients in a primary care setting. The take up for such services has been marked, and there is clearly patient demand for such a service. Whilst it may not be an attractive solution for everyone, innovation in primary care in the NHS has been limited to date, and there is a question to be answered as to how such disruptive technologies will fit with a population based approach to health and social care; but the increasing adoption of technology in society does appear to be influencing those seeking to find solutions to a health and social care system under pressure.

No doubt, the rise of technology in society has created opportunities for more patient choice; smart technology, wearable devices and the impetus to share data means that, with the increased focus on access to your own healthcare, patients are savvier about how they manage this. These are surely the building blocks for the future of healthcare.

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