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Medical workforce education and training: A failed decentralisation attempt to reform organisation, financing, and planning in England

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Abstract

The 2010–2015 Conservative and Liberal Democrat coalition government proposed introducing a radical decentralisation reform of the organisation, financing, and planning of medical workforce education and training in England. However, following public deliberation and parliamentary scrutiny of the government's proposals, it had to abandon and alter its original proposals to the extent that they failed to achieve their original decentralisation objectives. This failed decentralisation attempt provides important lessons about the policy process and content of both workforce governance and health system reforms in Europe and beyond. The organisation, financing, and planning of medical workforce education is as an issue of national importance and should remain in the stewardship of the national government. Future reform efforts seeking to enhance the skills of the workforce needed to deliver high-quality care for patients in the 21st century will have a greater chance of succeeding if they are clearly articulated through engagement with stakeholders, and focus on the delivery of undergraduate and postgraduate multi-professional education and training in universities and teaching hospitals.

1. Introduction

The organisation, financing, and planning of medical workforce education and training in England has been subject to numerous reforms since the government-run single-payer National Health Service (NHS) was established in 1948 [1-3], but its core principles have endured well into present days. Shortly after coming to power in 2010, the Conservative and Liberal Democrat coalition government proposed the most radical and ambitious set of reforms to reorganise the NHS since its establishment [4]. The overall vision for these reforms was to “liberate the NHS” from government control and bureaucracy by decentralising and devolving powers in the health system below a national level. Given that medical workforce governance functions are embedded in the NHS, the government attempted to decentralise these as well [5]. Importantly, this attempt took place in the context of economic downturn and the government’s commitment to decreasing growth in public spending.

Although many in the public and healthcare sector agreed with the government that the NHS required changes [6], the government reform proposals generated a heated public debate and were strongly criticised by members of the public and healthcare professionals alike [7]. In response, the government launched a listening exercise in order to "pause, listen, reflect and improve on [the government's] proposals" for the entire NHS [8]. As part of the listening exercise, the government also set up an independent group of 45 healthcare experts, known as the NHS Future Forum, to examine the government's proposals and make recommendations on the future of the NHS [9]. Moreover, the House of Commons Health Committee launched a parliamentary inquiry into health workforce education, training, and planning [10]. As a result of the listening exercise, public debate, and parliamentary scrutiny, the government reconsidered and altered some of its proposals to the extent that they failed to achieve their original decentralisation objectives.

This article analyses the proposed and implemented reform of the organisation, financing, and planning of medical workforce education and training in England during the Conservative and Liberal Democrat coalition government's time in office (2010-2015). The next two sections examine the policy positions of stakeholders on the key reform issues, such as the strategic planning and development of the medical workforce and financing of medical workforce education and training, the influence of stakeholders on the policy process, and the policies implemented following their public deliberation and parliamentary scrutiny. The final section concludes with an overall assessment of the reform and makes policy recommendations for future reforms.

2. Strategic planning and development of the medical workforce

Since the establishment of the NHS in 1948, healthcare in England has experienced rather distinctive arrangements compared with other European countries: it is centrally run and financed from general taxation with an aspiration to provide care for all, free at the point of use [11]. As part of these arrangements, the Department of Health – a ministerial department of the UK government politically led by the government minister, called the Secretary of State for Health – was responsible for all the NHS functions, including strategic planning and development of the medical workforce. The latter included planning the numbers of undergraduate medical students and postgraduate trainees and determining their specialty mix in consultation with professional regulatory bodies, such as Medical Royal Colleges and the General Medical Council (GMC). At the regional level, 10 strategic health authorities (SHAs) were responsible for the implementation and strategic supervision of government policy, including organisation, commissioning, and quality-management of postgraduate medical education and training programmes by postgraduate deaneries using the standards set by professional regulators [12].

In 2010, the government proposed to decentralise strategic planning and development of the medical workforce by moving it from the Department of Health to a new national body and devolving partial responsibility for it to healthcare providers at the regional level [5]. There were two central planks to the government's proposals for a new workforce governance system: 1) an autonomous statutory organisation called Health Education England (HEE) at the national level and 2) local education and training boards (LETBs) at the regional level. Health Education England was envisaged to be initially established as a special health authority and then transitioned into a non-departmental public body operating at arms-length from the Department of Health. Local education and training boards were envisaged as autonomous healthcare "provider skills networks" that would enable healthcare employers to decide how they would network to exercise their responsibilities in respect of planning the numbers and skill mix of the workforce that they would require in the future.

The public deliberation and parliamentary scrutiny of the government's proposals demonstrated that they were "vague and indeterminate" and had significant flaws [10, p.38]. Most stakeholders perceived that the government had failed to set out a clear vision for the reform, they were not adequately engaged in its deliberation, and ultimately the reform might not benefit patients [13]. Although employers, such as university hospitals, were expected by the government to be the major beneficiaries of the new system, they did not strongly support the government's proposals because they lacked the necessary infrastructure and resources for strategic planning and development of the medical workforce, and did not perceive it their core function. Professional regulators were not convinced there was any case for reorganising the whole system of workforce planning and development either and saw the proposed changes as being required primarily as a consequence of the abolition of strategic health authorities [14]. Likewise, many other stakeholders believed that the workforce planning and development functions would be more effectively provided at the national level [15, 16].

As a result of the reform deliberation and scrutiny, the government altered its proposals to the extent that the implemented changes failed to achieve the original decentralisation objectives. Health Education England was created as a special health authority of the Department of Health, i.e. a central national body fully accountable to the government, and was not transitioned to an arms-length body during the government's term in office, 2010-2015. Contrary to the original proposals to establish local education and training boards as autonomous networks of healthcare providers, they were established as statutory committees of Health Education England with an advisory rather than decision-making role. Although the creation of 13 such boards in place of 10 strategic health authorities allowed for a greater degree of regionalisation in workforce governance, the government centralised the running of the boards already in 2014 by abolishing a number of senior executive roles within individual boards to reduce administrative costs and simultaneously appointing four senior executives to run a number of boards while reporting directly to the chief executive of Health Education England [17]. Finally, the government had to reiterate the central role of the state in workforce planning and development by placing in legislation an explicit duty on the Secretary of State for Health "to secure that there is an effective system for the planning and delivery of education and training… as part of the health service in England" [18, pp.3-4].

3. Financing of medical workforce education and training

As part of the historical NHS financing arrangements, the government top-sliced the NHS budget to raise funding towards the costs of medical workforce education and training associated with NHS teaching hospitals' and general practices' overheads for clinical placements and salary support for trainees. This funding, known as the Multi-Professional Education and Training (MPET) budget, was then allocated to strategic health authorities and postgraduate deaneries at a regional level, which in turn commissioned clinical placements and training from local NHS healthcare providers and reimbursed them on the basis of locally-negotiated contracts. Alongside the NHS, there is a small independent private healthcare sector, serving approximately 11% of the population who have private health insurance [11]. Independent private hospitals and clinics employ NHS-trained medical staff, most commonly, on a part-time basis in addition to their NHS duties, but do not formally participate in the education and training of the NHS workforce.

In 2010, the government proposed to replace the national Multi-Professional Education and Training budget with a levy on all healthcare providers employing NHS-trained staff in order to ensure "that those who are chosen to train the future workforce are rewarded in doing so, and those that

undertake less training than they receive the benefit from, contribute to the training provided by others" [5, p.57]. Moreover, the government proposed that local individual health care providers should be responsible for the development of their existing healthcare workforce and that it would not be appropriate to use a national levy for this purpose [5]. Although many stakeholders saw some benefit in the prospect of raising additional funding for education and training from independent providers employing the NHS-trained workforce, the overwhelming majority of stakeholders preferred the existing funding arrangements. They felt that the government had felt to engage with them to explain the benefits of replacing the existing arrangements with a levy and that introducing such a levy would be technically challenging.

Policy positions and influence of key stakeholders on the policy process are plotted in Figure 1 using the approach developed by Geissler and Quentin [19], the authors' expert judgement, and the survey of medical education leaders [13]. Whereas the House of Commons Health Committee and professional regulators supported the government proposal, all other stakeholders opposed it. Executives of large university hospitals, which both train and employ medical workforce, feared that the cost of paying a new levy might be higher than the income from education and training contracts. Local education and training board executives and postgraduate deans, who commission education and training, felt that the new levy might result in adverse incentives for healthcare providers to employ fewer junior doctors or seek recruiting them from overseas. Likewise, medical school deans and directors of medical education, who take the lead for the delivery of the educational contract between their teaching hospitals and postgraduate deaneries, believed that medical workforce education and training is an issue of national importance that should not be left to the judgement and budgets of individual healthcare providers. Moreover, evidence from the parliamentary inquiry suggested that independent sector providers were strongly opposed to the idea of a levy [10], although they hardly had any influence on the policy process.

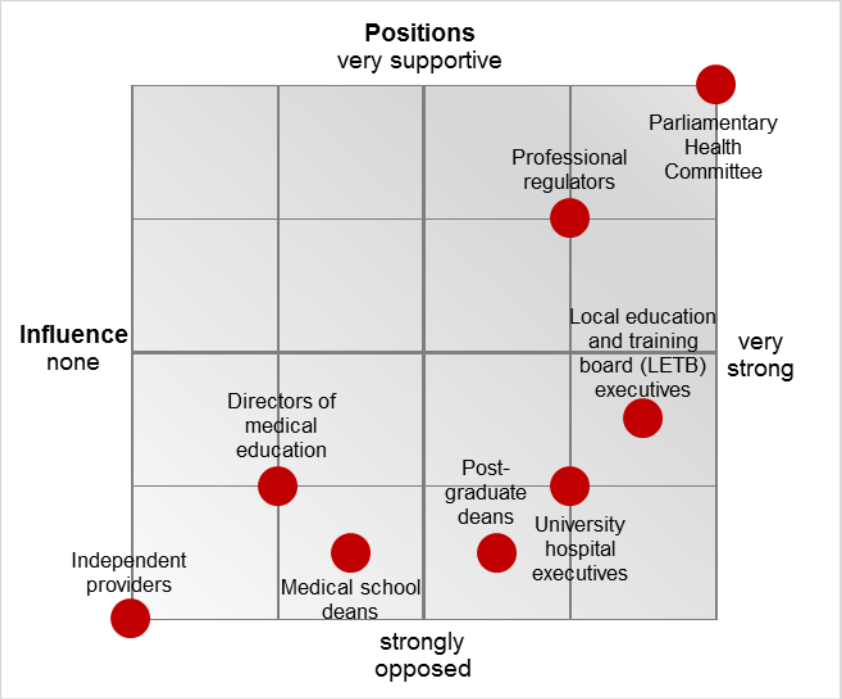

Fig. 1. Policy positions and influence of key stakeholders on the policy process. The majority of stakeholders with varying degrees of influence opposed the replacement of the existing financing arrangements for medical workforce education and training based on the top-slicing of the NHS

budget with a levy on all healthcare providers. Source: Authors' expert judgement and survey of medical education leaders [13].

Given that the majority of stakeholders questioned the benefits of introducing a levy on individual healthcare providers, the government put its proposals on hold and commissioned a report into the economics of provider levies [20]. The report highlighted that a levy could be an effective instrument to ensure that healthcare providers pay the marginal social cost of medical workforce education and training, and was broadly supportive of the introduction of a carefully priced levy [20]. By the time the report was published in 2013, the principal architect of the proposed NHS reforms, Andrew Lansley, had to leave his post as the Secretary of State for Health due to the strong opposition to his reforms. During its remaining time in office, the government did not put the proposals for the introduction of a levy back on the political agenda and the existing financing arrangements based on the top-slicing of the NHS budget prevailed.

4. Conclusions: assessment and outlook

Overall, the 2010-2015 Conservative and Liberal Democrat coalition government failed to achieve its original decentralisation objectives in the organisation, financing, and planning of medical workforce education and training in England. The public deliberation and parliamentary scrutiny of the failed government's proposals highlighted important lessons about the policy process and content of both workforce governance and health system reforms in Europe and beyond.

As far as the policy process is concerned, insufficient engagement with stakeholders during the formulation of the reform proposals and a lack of clarity about the costs and benefits of the proposed reforms led to the protracted policy deliberation and opposition of many stakeholders. These in turn resulted in the abandonment and alteration of the government's proposals to the extent that they failed to achieve their original decentralisation objectives. With regard to reform policy options, the majority of stakeholders recognised that the organisation, financing, and planning of medical workforce education is an issue of national importance and thus it should remain in the stewardship of the national government. Moreover, the majority of stakeholders did not appreciate the focus of the reform on the organisation, financing, and planning because it did not have clear benefits for the delivery of education and training to healthcare professionals and, ultimately, for patients. Although the government stated the importance of promoting multi-professional education and training and improving links with higher education institutions, the reform proposals predominantly focussed on the medical workforce and healthcare providers.

Future reform efforts seeking to enhance the skills of the healthcare workforce needed to deliver high-quality care for patients in the 21st century will have a greater chance of succeeding if they are clearly articulated through engagement with stakeholders and focus on delivery rather than organisation, financing, and planning. Policy-makers should examine international experience in order to identify effective policy options for better aligning undergraduate and postgraduate education and training of both physicians and allied health professions at the point of delivery in universities and teaching hospitals. It is hoped that this health reform monitor article will provide a further stimulus for research into workforce governance with a view to facilitating organisational learning between heterogeneous health systems in Europe and beyond [21-23].

Conflict of Interest statement

AMB is dean of medicine and head of the Medical Sciences Division, University of Oxford, UK, a member of the UK's Medical Schools Council, and a fellow of the UK's Academy of Medical Sciences. PVO declares no competing interests.

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