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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.

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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 the present day. 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 an 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

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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 following 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 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 number 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 decentralising 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 as 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 had already, by 2014, centralised the running of the boards 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).

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