Don Berwick’s Top Ten Tips

In his speech, during the 60th birthday celebrations of the NSH President and CEO Institute for Healthcare Improvement USA, Don Berwick offered the following top ten tips for the NHS to get better:

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.

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.

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.

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.

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.

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.

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.

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.

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.

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?