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PERSPECTIVE

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'There's the end of an auld sang': Farewell to the NHS market

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Abstract

The new White Paper, Integration and Innovation, prefiguring a Health and Social Care Bill for England, means that the NHS structure in England will have come full circle in the last 32 years, since the Thatcher government began in 1989 to implement the reforms announced that year in the White Paper, Working for Patients (incidentally without waiting for parliamentary approval, which came in 1990). This will be denied by some, who will depict the 'new' integration as only being possible as a result of learning during the various phases of reform over the last 30 years. This is a fallacious teleology. It is argued here that, while the 'old' NHS of the 1980s (of course) required improvement, the persistent 'reforms' of the last 30 years or so have been based on political fads which have been both hugely expensive and, in the end, transitory and self-defeating.

KEYWORDS
circular reform, end of the market, English NHS, market reform

The new White Paper[1] prefiguring a Health and Social Care Bill means that the NHS structure in England will have come full circle in the last 32 years, since the Thatcher government began in 1989 to implement the reforms announced in 1988 in the White Paper, Working for Patients[2] (without waiting for parliamentary approval, which came in 1990).

This will be denied by some, who will depict the 'new' integration as only possible as a result of learning during the various phases of reform over the last 30 years. This is a fallacious teleology, but let us give the argument its best shot.

Those who point to (at least partly) constructive evolution over 30 years, rather than fatuous and expensive circularity, point to the fact the 'new' integration includes GPs and (to an extent) local government and social care, as well as new ways of working which (they will suggest) it took various reforms to develop. The 'old', prereform NHS, they argue, was solidified in silos by the 'forces of conservatism', which it took the catalyst of 'market reform' to unpick.

This is, however, chronically misconceived. First, even if what began as a leaked document becomes a Health and Social Care Bill, then an Act, GPs will continue to be independent contractors who participate in (what will be statutory rather than voluntary) Integrated Care Organizations as a result of exhortation or incentive. Such innovation has been possible throughout the history of the NHS.

Second, social care services and local government participation will be enabled (or not) indirectly. Only by giving governance and control of the NHS to local government or control of social care to the NHS would a full integration be possible. That is not going to happen, especially not at the behest of a government which is seeking to 'take back control' of the NHS from a quasi-independent management board (NHS England). For one of the key aims of new legislation is to reverse the Health and Social Care Act of 2012, that is, the Lansley reforms, and indeed to overturn the ethos of 'arms length' managerialism first set out for the NHS by the late Sir Roy Griffiths in his NHS Management Inquiry Report of October 1983.[3]

Third, and most importantly, most of the innovations geared to collaboration and 'integration' (which has incidentally become a motherhood-and-apple pie term) have happened 'against the grain' of the reforms of the last 30 years, which have been geared variously to developing a healthcare market and/or *dis integrating* the NHS into separate organizations (various incarnations of provider Trusts; a bewildering succession of small 'purchasing' Trusts and 'commissioning groups'; and an ever-changing regulatory landscape which has rarely been fit for purpose).

In other words, what integration we have arrived at has occurred as a result of managers and clinicians working 'at street level' to make sense of a series of reforms which—taken at face value—would have been severely dysfunctional to the point of gridlock (an irony, since the reform era now drawing to a close was kicked off by Alain Enthoven's[4] striking but misleading diagnosis of exactly that, 'gridlock'). To put it succinctly, collaboration 'on the ground' has occurred by happy accident or through grim necessity.

The prereform 1980s NHS did of course require improvement. This was however technical and practical, not well served by ideological big-bang solutions. Quite apart from the waste of tens of billions of pounds[5] in implementing cataclysmic solutions in search of modest problems, the NHS could have been tweaked or steered in the right direction without the repetitive structural butchery it has suffered.

Some 'insider' commentators and advisers, as well as politicians, have sought to shift ground seamlessly to give at least two cheers to each stage of reform.[6] Again, let us be as fair as possible: it is a practical and personal calculation as to whether one can best operate from inside the tent or be outside the tent. But defence of reforms which *dis integrated* the NHS not only into 'purchasers and providers' but also into separate provider Trusts for hospital and nonhospital care—not by accident but by design—by those who now preach integration is facile.

The argument that the tortuous path taken over decades was necessary to reach today's vision of 'integrated care' is as tortuous in sanitising history as the reforms themselves were in tying the NHS up in expensive knots.

The argument goes as follows. The Thatcher-Clarke purchaser/provider split (if not the full 'internal market'), the Blair-Milburn fixed-price market and even aspects of Andrew Lansley's Ozymandian monument in the desert, the Health and Social Care Act of 2012 have in the end helped us reach an 'integrated' NHS qualitatively different from the caricatured 'bureaucratic old' NHS of the 1980s.

But this is an egregiously mythological eschatology—a grandiose *apologia* on the part of those who wanted to hug reforms close in order to stay inside the tent.

It is argued that the purchaser/provider split was necessary to allow need to be distinguished from existing provision, and an alleged bias to hospital care rectified. Not remotely true. What was needed was a distinction between assessing need, developing (or continuing) services to meet that need and managing said services.

There was not an over-provision of hospital care. Tell that to Germans, French or Swedes and they would be right to laugh. An unholy coalition developed in favour of the purchaser/provider split. As well as its Thatcherite progenitors, it attracted support from 'antidoctor' progressives who were suspicious of big hospitals.

A few other supporters had more reason behind their cautious support: they hoped it could lead to a more effective focus upon public health rather than business-as-usual, and sought to persuade Labour not to oppose it. But with hindsight they consider that to have been a dashed hope.[7]

There was not in any case 'too much hospital' in the NHS. There was both underfunding of mental healthcare and a need to bring hospital and community services closer together—not the same thing at all.

Cultural and managerial shortcomings are not best addressed by markets and purchaser/provider splits: to assume so is to make what philosophers call a 'category mistake'. What is more, if hospitals needed more discipline, making them autonomous Trusts was a bizarre way to go about it.

The Blair reforms[8] deepened the market, and confused patient choice (a worthy aim) with contracting by commissioners which were now far too small to be effective. This confusion happened because the Blair government did not build on the natural choice allowed in theory, but only patchily in practice, in the 'old' NHS (before the Thatcher reforms) through GP referral.

Blair and Milburn could have done this simply by funding patient flows more effectively. Instead they started all over again, or rather from the Thatcher-Clark inheritance of putting contracts before choice (in which the patient followed the money rather than the money following the patient).

This meant constructing an inflexible national scheme of 'managed choice' which soon played second fiddle to the budget constraints of small and inefficient 'commissioners'—which were nought more than purchasers, if even that: more often they were panic-buyers.

It was a bit like what the Johnson government did recently, in late Spring 2020, with its soon-to-be-ill-fated Test and Trace programme: it created an inflexible, 'tick box' national scheme. It eschewed local expertise, in this case of the more far-sighted GPs who had worked with patients groups on referrals in line with their preferences long before the market reform era dawned—when competitive reform of the NHS was merely a gleam in the eye of marginalised neo-liberal think tanks.

The Thatcher market was a paper chase replicating existing practice at great expense, except in those rare areas where price-competition did emerge, promoting a race to the bottom (cheap and not-always-cheerful care).

The Blair market at least sought to learn from this, by mandating fixed prices via a national tariff. The aim was that providers would attract business by increasing quality within a fixed-price envelope.

But this too was misconceived. Most hospitals had had no problem attracting patients; indeed, the problem was getting paid adequately for uncontrolled referrals and crowded accident and emergency departments. Moreover where quality improvement was sought by clinical departments, there was rarely an organisational incentive to back it unless it was cost-neutral or cost-saving: the NHS is not Waitrose, and cannot simply get richer customers paying more for quality.

So what to be done, if both price competition and fixed-price competition do not work? Rationally, the answer was to abandon playing at markets and develop a grown-up collaboration on service development within unified authorities. It's what the rest of the UK was doing by now, after all.

But instead, in 2010, we got Andrew Lansley, who had been Prime Minister David Cameron's boss back in his days at the Conservative Research Department. Cameron gave Lansley his head to marketise even further, as a sop to those Conservatives who were suspicious of the PM's love-in with the NHS. Lansley's reforms[9] were hugely bureaucratic and disruptive—more a hybrid monstrosity than market machine. Like most market reforms promising

the taming of bureaucracy to please the tabloids, the Lansley legacy achieved the opposite. The rest is (recent) history.

One of the most politically striking and substantively astute sections of the White Paper leaked in February 2021 makes it clear that it is possible to retain the analytical and practical distinction between planning ('commissioning') and providing health services, yet combine these in the one cohesive organisation.

Politically striking because it comes from a hard-Right government. Astute because—for once—politicians have learned the right lesson from recent mistakes.

I have advised a number of Health Secretaries and Shadows of both main parties, and non-political policy-makers over the years—from the late Robin Cook, then Shadow Health Secretary, in 1991, onwards until 2015—that 'market reforms' are wasteful and counter-productive. It is possible to combine patient choice and incentives to cost-effectiveness without them, indeed easier so to do, before one even adds in the *desideratum* of integrated care. These tripartite aims could have been developed organically at the end of the 1980s.

It is a great advantage, if a great irony, that it is now a Conservative government undertaking such a reintegration of the NHS. Had Labour done so—whether the party of Blair, Corbyn or Starmer—the Tories would have called it a return to the bad old days of bureaucratic planning, and some latter-day Lansley-esque obsessive or throwback Thatcher tribute-act would have sought their political monument in abolishing it.

But a government of the Right abolishing the market is an example of what used to be called the 'Nixon to China' approach—only a Republican President who has built his career in anticommunism could meet Mao; only the Conservatives can fully embed a sensible policy of which ideological right-wingers will be deeply suspicious.

Just ask Labour. New Labour's Alan Milburn in opposition in the 1990s was a very effective hammer of the wasteful Tory internal market but then ironically the architect of an even more Kafka-esque version of 'market reforms' than Thatcher's, when he became Blair's Health Secretary. He was motivated in his latter incarnation less by evidence that returning to 'market reforms' was desirable than by a quasipathological desire on the part of Tony Blair and himself to prove (to the Tory media) that New Labour's NHS was a shining model of market reform and not an advert for Old Labour ways; to gain cross-party legitimacy with an eye to the future.

It did not work, as the Conservatives, right-wing think-tanks and Tory tabloids variously damned Milburn's *Danegeld* to the Daily Mail as a bureaucratic mess (with some justification, as Milburn's market NHS *was* hideously bureaucratic).

The fact that Cameron unforgivably then gave Lansley his head to make things even worse is of course another matter. And worse still: Cameron, pressured by his Liberal Democratic coalition partners, panicked and forced Lansley to accommodate reforms to his reforms, jerrymandered via the NHS Future Forum,[10] which left them truly incoherent, neither fish nor fowl. We then had the irony of Labour's Milburn attacking the result for not being robust and market-friendly enough. Oh what a tangled web.

It is a pity of historic proportions that this Conservative government is doing such a worthwhile thing as reintegrating the NHS in the slipstream of its appalling record on Covid-19. Indeed it may well be preparing for a new Health and Social Care Act now to deflect blame for its chronically weak management of Covid.

Indeed, for students of political history, there are shades again of Richard Nixon, who—as Watergate closed in—sought to distract attention by proposing a National Health Insurance initiative, in normal times anathema to Republicans like himself; an initiative which the late Senator Edward Kennedy is on record as regretting not taking up for reasons of partisanship and distaste for the old enemy. Maybe this NHS and social care initiative is Johnson's would-be diversion from 'Covidgate' and the inevitable Inquiry into its mishandling.

But at the end of the day, what is planned is still the right answer.[11] Routine tendering for services, both expensive and demoralising, is to be abolished. A rigid tariff for services is to be made more flexible, although the devil will be in the detail. The fragmentation of agencies heading up the NHS at national level is to be ended. And most importantly of all, local NHS authorities will bring together hospitals, other providers, commissioners (planners) and GPs.

Some may regret the end to a quasi-'autonomous' national NHS board. And, sure, if direct political control is of the malign variety, policy suffers. But in a tax-funded, politicised service, the managerialist vision of being 'arms length' was always a pipedream, and a recipe for behind-the-scenes skullduggery rather than honest political ownership.

Former Conservative Health Secretary Jeremy Hunt, now Chair of the House of Commons Select Committee on Health, has welcomed the approach in the new White Paper. Former Prime Minister Theresa May in 2018 and NHS England and NHS Improvement (now to be merged), in a joint paper in September 2020, prefigured it with their own stated intentions. So all that remains now to cement the approach beyond partisanship is Labour approval.

This should be granted to what can easily be seen in political symbolism as a quintessentially left-of-centre approach to the NHS, although in essence it is a non-partisan nod to effectiveness over ideology. Sir Keir Starmer is the right leader to enable Labour to be constructive. He started out trying to support the government wherever possible in the fight against Covid but Boris Johnson's serial recklessness and incompetence in dealing with the pandemic made that unsustainable. On this issue however, supporting the government should be easier.

That is of course assuming that it is well-implemented. At the centre, if Simon Stevens is in charge of the NHS, there is every prospect that it will be. He has shown himself to be pragmatic in prioritising service needs over the ideology with which he once was identified as Milburn's, then Blair's, health advisor.

A problem may lie more with the culture of what will become newly-statutory Integrated Care Organisations (incidentally a terrible name—who's for local health authorities?). Many Chairs are seasoned *apparatchiks* who have been brought up on that incongruous combination of market and command and control culture which has evolved over the past few decades. Can a leopard change its spots? Watch this space.

When the Scottish Parliament was abolished in 1707, Chancellor Seafield exclaimed at the touching of the Act of Union with the sceptre, 'There's the end of an auld sang'. It was to be 292 years until the Scottish Parliament reconvened. Let us hope it is another 292 years before another succession of ill-judged reforms to the English NHS takes a series of sledgehammers to crack a rather delicate nut.

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DATA AVAILABILITY STATEMENT

Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

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