NHS Reform and Health Politics in the UK

Revolution, Counter-Revolution and Covid Crisis

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For Tracey, Leah and Josh, with all my love. As ever, you put up with me.

Preface

This book analyses more than thirty years of ferment in UK health policy, focussing upon England but with the rest of the UK contrasted where relevant.

Part I draws partly on my 2016 book in telling the story of more than twenty-five years of persistent NHS reform—from the Thatcher Review in 1988–1989, which led to the 'internal market', to the very beginning of the end to market reform signalled in 2015. The market years had seen an attempt to change the NHS from a planned public sector organisation to a market, in a process which I then termed 'permanent revolution'. In this book, the material from my 1916 book is substantially edited.

Part II shows how these reforms were gradually reversed, culminating in the Health and Care Bill of 2021 (passed in the House of Commons and close to being passed in the House of Lords, at the time of writing in February 2022), which I now characterise as 'counter-revolution'.

Care is required in interpreting this 'counter-revolution' as the end of the market in the NHS: one can 'never say never' in the minefield of health politics, which reflects the wider politics of the day. And in 2022, politics was especially febrile. Even before the new bill was passed, the Health Secretary, Sajid Javid, had blithely proposed a throwback to 'autonomous hospitals', which were in the process of being *de facto* abolished in the legislation sponsored in Javid's name. Even by English health policy standards, this was chaotic. So, any judgement on the abolition of the market must be provisional.

Nevertheless, the intention of the Health and Care Bill was clear: the market was an unaffordable distraction. But getting rid of it was not enough. The Covid pandemic meant that the luxury of assuming that structural reform could render the NHS stable was unavailable. The market reformers who had subjected the English NHS to continual re-disorganisation from 1988 to 2012 had justified their actions as making the NHS sustainable yet had actually destabilised it. But this had not been fatal, in less troubled times. The moves from 2015 onwards to 'reintegrate' the NHS were indeed *necessary* to restore some sanity at ground level. But sadly, they were and are by no means *sufficient* to secure the future of an NHS battered by the pandemic. Part III analyses the flawed, indeed disastrous, response to the Covid pandemic in the UK.

Moreover, the pandemic threw into sharp relief the fact that the NHS market reforms of yore—despite the extant moves to abolish them—still cast a long shadow over the capacity of the wider healthcare system to plan for the future. These reforms had carelessly abolished or undermined a variety of national, regional and local agencies which aided the wider concerns of public health and health protection. This was, in part, accidental: the various reforms had often squeezed public health and health protection into new organisational structures, created for other purposes, as an afterthought. 'Market reform' had often carelessly abolished or undermined national and regional agencies without regard to wider consequences.

The story of the pandemic is told in Part III against this backdrop. Moreover, the failings in UK policy to combat the pandemic had also been exacerbated by a much less accidental, indeed clearly deliberate, component of market reform—to subjugate independent professional power to managerialist diktat, which in practice meant political control. (Politicians in Westminster, when they talk of managerial leadership, often mean managerial followership.)

Part III's story overall reminds us that structures and structural reform can only help or hinder: the pandemic in the UK provides a story primarily of failed political leadership. The fact that it was ironically the same politicians who flunked the pandemic who became responsible for the Bill to 'reintegrate' the NHS (an irony analysed in depth below) should remind us that even a sensible reform may well not be safe in the wrong hands.

The focus of Parts I and II is squarely upon market reform and its reversal, and Part III's treatment of the pandemic primarily concerns flaws in decision-making. As a result, this book does not deal with 'public health', except briefly in the case of the pandemic when drawing attention to the shortcomings of post-2012 public health structures. Clearly public health is a major, perhaps the major, issue in terms of the health of the nation. The NHS was responsible for public health from 1974 to 2012: even subsequently, after local public health was returned to local government, there inevitably remains a strong interface with the NHS. The NHS moreover is a major employer, and often the central institution, in deprived areas and its role as an advocate for tackling health inequalities can be significant. The works of Hunter (2003, 2010) provide insight into the key issues in public health; and Hunter (2016) discusses *inter alia* the return of health to local government in England.

The NHS faces a rocky future. It was always frustrating, if predictable, that because I analysed the circular fatuousness of 'the reforms' between 1990 and 2015, I was accused of assuming that the 'old NHS', before the brave new world of the market, was perfect. The idea that *either* the pre-1990 NHS *or* any present and future version is perfect simply as a result of 'reintegration', could not be further from the truth.

The NHS actually needs very different reform from the type to which it was subjected in England from 1990 until recently. We need to address how patients access services, unlike the tinkering and tampering with organisational structures which reform has been, or become, in the years of permanent revolution. We need a fundamental rethink to promote timely, direct access to specialists and other *genuinely* pro-patient changes, as opposed to the previous market reforms which contained lots of warm words and snazzy titles stressing 'the patient' but were remote from the patient's real needs. Part IV explains this.

Post-pandemic, I am not sanguine that these needed changes will be forthcoming or that the NHS will survive as a universal service (except for emergency, complexity and 'bog-standard' general practice) too far past its 80th birthday. It might, sadly, in the longer term, be yet another body from the ranks of the over-80s joining those 'piled high' by the pandemic, to call on the phrase attributed to Boris Johnson by his former chief

adviser, Dominic Cummings. ('Let the bodies pile high in their thousands'.) As an analyst of health policy for more than 40 years, I certainly hope that this is not the case. But there is no current cause for optimism, let alone complacency.

Stoke-on-Trent, UK
February 2022

Calum Paton

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Contents

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Calum Paton is Emeritus Professor of Public Policy, Keele University, UK. His previous books on the politics of health policy and NHS reform in the UK, especially England, have covered the Conservative reforms in the 1990s, New Labour's reforms from 1997 to 2007 and the Coalition government's ill-fated Health and Social Care Act of 2012. Other books he has published cover health politics and policy in the USA and Europe. He was Editor-in-Chief of the International Journal of Health Planning and Management (Wiley) from 1998 to 2019. He has advised leading politicians and agencies in the UK and a variety of governments overseas; undertaken consultancy for international organisations such as the EU and a range of global agencies; and chaired the board of one of the UK's largest NHS hospitals.

Abbreviations

A&E	Accident and Emergency (Hospital Department)
ACO	Accountable Care Organisation
AHA	Area Health Authority
AIDS	Acquired Immuno-Deficiency Syndrome
BBC	British Broadcasting Corporation
BMJ	British Medical Journal
Brexit	British exit from the European Union
CCG	Clinical Commissioning Group(s)
CEO	Chief Executive
CHI	Commission for Health Improvement
CMA	Chief Medical Adviser
CMO	Chief Medical Officer
COBRA	Cabinet Office Briefing (meeting)
COHSE	Confederation of Health Service Employees
CPS	Centre for Policy Studies
CQC	Care Quality Commission
CSO	Chief Scientific Officer
DHSC	Department of Health and Social Care
DHSS	Department of Health and Social Security
DoH	Department of Health
ECR	Extra-Contractual Referral(s)
EEA	European Economic Area
ERM	Exchange Rate Mechanism
EU	European Union
FT	Foundation Trust
G7	Group of Seven (countries)

GDP	Gross Domestic Product
GP	General Practitioner
GPFH	General Practitioner Fund-Holding
HA	Health Authority
HCB	Health and Care Bill, 2021
HCC	Health Care Commission
HMO	Health Maintenance Organisation
HSA	Health and Safety Executive
ICS	Integrated Care System
IPSO	Independent Press Standards Organisation
ISTC	Independent Sector Treatment Centre
ITV	Independent Television
MCP	Multi-specialty Community Provider
MD	Doctor of Medicine
MERS	Middle Eastern Respiratory Syndrome
MHRA	Medical and Healthcare products Regulatory Agency
MP	Member of Parliament
NALGO	National and Local Government Officers
NHS	National Health Service
NICE	National Institute of Clinical Excellence
NPM	New Public Management
NUPE	National Union of Public Employees
OAT	Out of Area Transfer
OECD	Organisation for Economic Cooperation and Development
ONS	Office of National Statistics
PAC	Integrated Primary and Acute Care system
PBC	Practice-Based Commissioning
PBR	Payment by Results
PCG	Primary Care Group
PCR	Polymerase Chain Reaction
PCT	Primary Care Trust
PEC	Professional Executive Committee
PFI	Private Finance Initiative
PHE	Public Health England
PM	Prime Minister
PPE	Personal Protective Equipment
PS	Permanent Secretary
RNA	Ribonucleic Acid
RT	Regional Team
SAGE	Scientific Advisory Group for Emergencies
Sars	Severe acute respiratory syndrome 1
Sars-CoV-2	Severe acute respiratory syndrome (Coronavirus) 2
SDP	Social Democratic Party

SGT	Self-Governing Trust
SHA	Strategic Health Authority
SNP	Scottish National Party
SPI-B	Scientific Pandemic Insights group on Behaviour
SPI-M	Scientific Pandemic Influenza group on Modelling
STP	Sustainability and Transformation Partnership
TCA	Trade and Cooperation Agreement
TPP	Total Purchasing Pilots
TTIP	Transatlantic Trade and Investment Partnership
U.S. or USA	United States of America
UK	United Kingdom
UKHSA	United Kingdom Health Security Agency
UNISON	Trade Union
UNITE	Trade Union
WCC	World Class Commissioning
WHO	World Health Organisation
WTO	World Trade Organisation

CHAPTER 1

Introduction

In my 2016 book about 'market reform' in the NHS, I used the term 'permanent revolution' in whimsical reference to Trotsky and Mao. It did not help that the English NHS's 'permanent revolution' was as doomed to fail like that of Leon Trotsky and as duplicitous as the 'continuous revolution' of Mao Zedong. Trotsky coined the phrase as a rejection of 'socialism in one country' but never saw his goal of permanent revolution to supplant capitalism globally achieved. Mao's version of continuous revolution (unlike Trotsky's, *within* communism) was a charlatan's means of retaining power by victimising his more practical comrades who were actually running things.

The NHS's continual ferment from the 1980s until 2015 owed more to Mao than Trotsky in that it was about reinventing an already-established NHS. Continual revolution in the NHS, what is more, offered a salutary case study of the futility of never-ending upheaval. And the NHS's revolution shared something else with communist history: the contradictions of the NHS market were addressed through (a very British) Stalinist management stepping in to sort things out.

NHS central control was the reality that dare not speak its name, being the opposite of what the market reforms over 30 years were supposed to be about. More centralism than the pre-reform NHS had ever seen was the paradoxical consequence of an impractical blueprint for reform which created confusion in NHS service planning and provision.

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It was up to those 'Stalinist' central NHS managers and their henchmen in the service to clear up the confusion, ironically at the behest of the same politicians whose naive ideas had caused the mess in the first place. To exhaust my jokey analogy with the titans of Communism: David Nicholson, NHS Chief Executive (2006–2014), was a former member of the Communist Party; he had to tackle the mess made by the reforms of Health Secretary Alan Milburn, a former Trotskyite whose previous managerial experience amounted to running a lefty bookshop named Days of Hope, known locally as Haze of Dope. And Nicholson then had to tackle another mess, this time created by one of Milburn's successors, Andrew Lansley.

By 2015, the NHS had had enough of all this. Top-down wheezes, fads and fallacies from the realm of high politics were just getting too ridiculous. For the first time, from 2015 onwards, there was a new approach, a quiet counter-revolution in which rationality and politics were aligned.

Ironically, many of the policy pundits and management consultants who supported market reforms now supported the abandonment of these reforms. They covered their tracks by arguing that the years of the market provided necessary staging posts on the route to the 'new' integration. Do not believe them: they are indulging in self-serving sophistry. I explain this in Part II, in analysing the counter-revolution in the English NHS in England which followed the market revolution of Part I.

The NHS Chief Executive appointed in 2014 was aware of the NHS's double-edged predicament—reform fatigue and a shortage of money. Soon, Simon Stevens trailed 'reintegration' in his first paper as CEO, *NHS Five-Year Forward View*. This was a break with Stevens' past record at the Department of Health, but then he always was more of a political animal at heart than a market reform junkie. He influenced politics now, by pulling politicians in his direction, more than his predecessor David Nicholson had been able to do when confronted with the steamroller that was Andrew Lansley.

Stevens' skill now lay in seizing the new agenda and sponsoring it at the political centre. He was helped by the fact that the Conservative Health Secretary who followed Andrew Lansley, Jeremy Hunt, was struck by the mess left by his predecessor.

Fast forward six years and the Health and Care Bill of 2021 was rightly presented as the encapsulation of changes already underway. Since 2012, NHS chiefs had had to 'manage' a whole series of market reforms by moderating, diverting and working around them. Thus the 2021 Bill was

an attempt to align health policy with the needs of service planning and management.

Stevens called it the final 10% of the task. It was more than that but no doubt he did not want to suggest another major 're-disorganisation' to a government which, post-Brexit and peri-pandemic, post-Brexit and peri-pandemic, already had much more on its plate than it could handle.

Most of the analysis in Parts I and II of this book concerns England. Part 1 however sets England in the context of developments elsewhere in the UK, and Part II explains how the latest English structural reforms are a timid move in a direction towards where the rest of the UK already sits.

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Market reform in England's NHS now seemed to be a historical episode rather than a live policy choice. For those who wish to revisit these reforms, the following three references assess, respectively, the internal market of the 1990s, New Labour's market reforms after 2001 and the Coalition government's 'Lansley reforms' of 2012: Le Grand (1998), Mays et al. (2011), Exworthy et al. (2016). My own previous books about NHS reform have sought to explore and explain unintended outcomes, especially of the perverse sort (Paton, 1998, 2006, 2016). This last book also sought to provide theoretical explanations for continuing market reform in England from the standpoint of political science. Leading contributions which also do this include Hunter (2016), Baggott (2015), Klein (2013), and Harrison and McDonald (2008).

Even where the English market reforms were irrational or at least *arational*, the reason for the rest of the UK abandoning the internal market (after devolution) and subsequently ignoring the English way, was of course political as well as rational. The devolved parliaments and assemblies were eager to be 'anyone but England', as Scottish football supporters sometimes put it.

The question still remains, then: even if it were rational so to do, why did England's *politics* allow the abandonment of market reform? After all, the story told in Part I is of politics ignoring rationality.

Was it because of a sea change in English politics? The answer is no. It was a right-wing Conservative government that sponsored the Health and Care Bill of 2021, which is, on the face of it, puzzling. But other factors were at play. This was a government led by a showman in Prime Minister, Boris Johnson, a politician with more interest in putting on a performance than in previous Conservative NHS reform or Thatcherite fiscal puritanism.

Even more importantly than this, however, Johnson had too many fires to fight to worry about the governance of the NHS. It was Health Secretary Matt Hancock who put the *imprimatur* on the abandonment of market reform by sponsoring the Health and Care Bill of 2021. And it was the previous government, Theresa May's, which had responded positively to the groundswell from the key professional and management bodies in the English NHS for a new approach. That said, Johnson was at that point on the same page: when Hancock was replaced as Health Secretary by Sajid Javid in July 2021 and the latter asked to pause the Health and Care Bill, the request was refused. Whether or not Javid's Thatcherite inclinations would cause problems in the future remained to be seen.

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The Covid-19 pandemic changed everything. The reversal of the market revolution, so significant in itself, is tame stuff by comparison with the Covid debacle—as indeed are the decades of the market revolution. The minor improvement to the English NHS which was likely to be occasioned by aligning policy and practice was swamped by Covid-19—the biggest public health failure in the UK's history, and that's official, according to the House of Commons Joint Committees Report (see Chapter 10 in Part III).

A policy failure of epic proportions was caused by governmental incompetence, a reckless Prime Minister and a sadly-reduced official scientific establishment. Part III documents this disaster and, in the process, shows how the 'continual revolution' over preceding years had made the management of the pandemic worse still by chronically weakening the UK's and especially England's public health protection structure. Even so, such fragility did not excuse the mismanagement of Covid: it was the UK's misfortune to have, at a time when it required sober risk-aversion, a Prime Minister whose approach to politics had always been the antithesis—risk-taking and gambling (Bower, 2020). Now more fatally than ever before, Johnson gambled repeatedly, during the pandemic.

By February 2022, the government behaved as if the pandemic were over: Johnson announced the early end of all restrictions, including the need to isolate even those with Covid—the apotheosis of recklessness on the part of a Prime Minister now facing his own demise. Whatever the future of Covid, the NHS in England in particular and the UK in general now confronted a dire situation. Part IV explores the reasons for this.

Post-pandemic, the situation facing the NHS is not just a short-term problem. During and after the pandemic, waiting times had worsened drastically as a result not of lockdowns but of Covid itself. The overall waiting list in October 2012 stood at nearly six million people. Brexit, the festering sore of social care and an inherited deficit in hospital beds and shortages of clinicians did not help. Many relatively poor people were now looking at the private sector even for GP consultations. The NHS was no longer capable of giving timely access to a GP in many cases, let alone responsive care by a specialist for non-emergency needs, and even emergency care was creaking at the seams in many parts of the country.

Therefore the ending of market reform was not a sufficient condition for improvement: it was merely a necessary condition for not wasting more time and (now much scarcer) money. Part IV emphasises how tall is the order of challenges facing the NHS.

What was needed for the future, if the NHS were to survive and prosper, was a sharp improvement in the quality of services, which had been pared ragged by the pandemic, and the establishment of timely access to those services. This was additional to perhaps the biggest challenge of all—the improvement of public health. But the mismatch between the challenge and the resources to meet it was huge.

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PART I

The Market Revolution

Check for updates

CHAPTER 2

Conservative Ascendancy: The 'Internal Market'

The Internal Market—Technical Fix or Political Fist?

The mechanism christened the 'internal market' by Alain Enthoven (1985) was first suggested as a technical solution to a practical problem in the NHS, not as an ideological alternative to public service. It was initially seen as a means by which 'money could follow the patient', by those who believed that this was not possible under the pre-reform NHS. Thus, it was about efficiency rather than ideology, although I think that it was and is a mistake to believe that market mechanisms within the NHS are likely to be efficient.

It is true that those economists who advocated it or supported the idea were mostly free-marketeers or neo-liberal stalwarts, such as those associated with the Institute of Economic Affairs who sensed that the tide of history might be turning against 'statism'. Yet at this point, the ideology of the market was embedded neither in public service discourse in general nor the culture of the NHS in particular. It was only much later that the Thatcher reforms to the NHS were interpreted as having been launched as a response to a social climate of anti-statism or, less controversially, 'consumerism'. But there was no 'consumer tide' or demand for 'patient choice' from patients or the public on any meaningful scale. This is a post hoc rationalisation for the 'inevitability' of reform.

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Just as the intellectual supporters of the idea had included those of neo-liberal bent, of course the politicians and advisers in the Thatcher administration who were enthusiastic about the idea included those who saw it in grander terms as part of the fight-back against the state and the public ethos. Thatcher's Health Secretary from 1987 to 1988, John Moore, was for example associated with the neo-liberal Mont Pelerin Society the initiators of which had included Hayek (1944) and Friedman (1962). But those who came to support the Thatcher reforms, including the lady's old enemy Kenneth Clarke, the Health Secretary (1988–1990) most associated with them, often did so for pragmatic reasons, or at least for managerial reasons rather than ideological ones.

Indeed the internal market was a Janus-faced policy. To some it was a half-way house to more thoroughgoing anti-statist reform to health-care. To others, it was a means of keeping the NHS flame warm in a cold political climate: that is to say, it preserved public provision while embracing reform enough to please the Thatcherites. Indeed John Moore had wanted more thoroughgoing privatisation, and a move to an insurance system for financing. It was his inability to come up with any practical or affordable scheme for such which finished him off politically after only one year in the job, along with the Chancellor Nigel Lawson's justified scepticism that such privatisation would allow financial control (Lawson, 1992).

Margaret Thatcher eventually saw the idea as being in tune with her own personal anti-statism, admittedly, although it is interesting to remember that she had shunned the idea when it was presented by Enthoven at a private seminar in Downing Street in summer 1984 when he was working on his monograph. This was ironical: aware of his dubious status in NHS circles as the potential privatiser from California, Enthoven was at pains to present his 'market' idea as compatible with public sector health services, as a kind of 'market socialism'. Presenting it thus to Thatcher was however to treat with kid gloves the one part of Enthoven's audience where such soft-soaping was unnecessary. He was shown the door and it was left to Dr. David Owen, inter alia the former Labour Health Minister and by now leader of the Social Democratic Party, to adopt the idea later on as a public sector reform without overtones of privatisation, having procured Enthoven's report from the Nuffield Trust before its publication.

It may be rational to rationalise a private, non-competitive system through the application of competitive pressures, possibly temporarily,

in certain social insurance systems such as Germany, Switzerland and Belgium. But the NHS's problems were not amenable to such a 'solution', which created new costs and inefficiencies rather than diminishing those already existing (Paton, 1996).

This book does not examine the vast literature on the role of markets in health systems generally or the large amount of research on the UK internal market, although Chapter 5 considers the cost of market reform in England. The aim here is primarily to tell the political story.

Planning and Markets

What, then, was the technical problem to which markets were alleged to provide the answer?

In the 1980s, the NHS was experimenting at the regional level (in England) with different ways of funding hospitals and district services at sub-regional level. Simplifying somewhat, there were two main approaches: firstly, using a formula to allocate resources from the Region to District Health Authorities according to population need as measured by the formula; and secondly, developing regional plans for where to site major services (such as the larger hospitals) and then sending the money to match such developments (both the 'capital' money for developments and the 'revenue' money for recurrent costs). The former approach can be termed 'resource-based planning' and the second approach 'plan-based resourcing' (Mays & Bevan, 1987; Paton, 1985).

One of the main reasons that it was difficult to allocate all or most funds to the more local Districts (of which there might be typically eight or ten in a Region) was because of patients flowing across the boundary from their District of residence to another District for treatment, if not out of the Region altogether. It was possible to fund the receiving District or Region directly for such so-called 'Cross-Boundary Flows'—or at least to adjust the formula for allocating resources to take account of such flows. This seemed straightforward in principle even though there were numerous alternative options at the technical level as to how to do it. But there was a non-technical reason for the difficulty, or at least a reason which straddled the technical and the political—in the sense of raising the spectre of the overall adequacy of NHS funding, and therefore taking the debate from 'low administration' into 'high politics'.

In a nutshell, if patients crossing boundaries were costed at the actual or average cost for their specialty or diagnosis, then this became the tail

that wagged the dog in terms of funding—for what was left over for the core residential population—the clear majority, in most cases—which did not cross the boundary was, per capita, significantly less per capita receiving treatment and/or per population need. This was because there was not enough money in the system—at prevailing costs, at least—to ensure that all 'needed' care could be reimbursed (i.e. hospitals and other providers paid). The result was rationing, or more accurately unmet need, since it was not a systematic process that deserved the name of rationing.

In a system where Districts were responsible both for accounting for local need and for running their local services, there was no intrinsic reason to cost at the level of individual patient care—and it is a serious misconception that this is a desirable or necessary feature of any health-care system. One of the comparative advantages of the NHS used to be that it could account for salient costs without 'individual billing' (whether that billing is for commercial purposes or for 'internal' accounting or contracting purposes). Yet where the lack of adequate resources—for the overt purposes of the system; this is not (only) a value judgement—was being fudged, it came to be seen as desirable that the discrepancy between the two types of patient (those treated locally and those flowing across boundaries) be tackled.

Enthoven—A 'Man from Mars'

On a parallel track in the mid-1980s, and without any ideological desire to promote markets (quite the reverse, if anything), the Nuffield Trust had invited Alain Enthoven, a health policy reform advocate from the USA, to comment on the management of the NHS—hence the title of his short 1985 monograph, 'Reflections on the Management of the NHS'. Enthoven, aware that he might be seen as an outsider out of sympathy with the NHS, had wanted to call it 'A Man from Mars Reflects on the NHS', but the Nuffield Trust's traditionalist Chairman Sir Edgar 'Bill' Williams had vetoed this title.

Enthoven's main stimulus to describe what he called 'gridlock' in the NHS was his perception that the famous London teaching hospitals were being denied adequate resourcing for what they did by the fact that the 'money did not follow the patient'. He meant that such hospitals were not adequately paid for those patients who flowed into London for care, especially of the more specialist variety.

Yet Enthoven was wrong about this. The hospitals were reimbursed according to the formula for the average speciality costs of such patients, at least in terms of their Districts' target allocations. Now it can be fairly pointed out that it took a long time for target allocations to be realised in practice (as achieving this involved winners and losers, with the resulting political complexity) and indeed also that, even when the District received the money, that did not guarantee that it would reimburse such hospitals pro rata for what they had 'earned'. But these factors were less material than the fact that the hospitals were underfunded more because their host Districts (e.g. Lambeth District, with St. Thomas's and Guy's hospitals) were not getting enough money from the Regions and central NHS 'above' for their local residential populations.

It was pointed out at the time that these hospitals rightly considered it in their financial as well as clinical interests to receive the flows from outside the District. The argument for an 'internal market' was thus initially based on a false premise—that the existing system did not reimburse care for patients who 'chose' (or rather, had the choice made for them, in most cases, by the GP) to go outside the locality.

Now this does not alter the fact that there is an argument for costing all care overtly, even as a means of exposing the degree to which the NHS is underfunded at existing levels of available services and efficiency. But this is not on its own an argument for a market, and for contracting between 'purchasers' and 'providers'. Nor does it determine whether such an exercise should occur at the level of the specialty, the patient group (e.g. Diagnosis Related Group or Health Related Group) or the individual patient. It is 'horses for courses': it depends what one needs the information for. But the rewriting of history has extended to a conflation of market mechanisms and information requirements. And Enthoven's short commentary had produced a soundbite—the 'internal market'—which would prove useful when politicians had boxed themselves in 1988–1989.

The Thatcher Factor

A third separate political track concerned the growing frustration of the Prime Minister personally with taking the flak for alleged NHS underfunding, during the winter of 1987–1988, ironically just after another convincing general election victory in which health had hardly featured. It was this that led her to make attack the best form of defence, in

launching what she called on BBC Panorama in January 1988 a 'fundamental review' of the NHS—unknown to her Health Secretary, the hapless John Moore. When Moore's stewardship, of what soon became known as the Prime Minister's Review of the NHS, proved hopeless, Kenneth Clarke was brought in as Health Secretary in July 1988.

Clarke was a managerialist rather than an ideologue, and—when Thatcher belatedly realised that the 'internal market' idea could suit her—he became the midwife for the policy. His experience as Minister of State at the DHSS in implementing Roy Griffiths' management reforms (Griffiths Report, 1983) was useful. Clarke always saw the internal market as a means of putting the metaphorical bomb under what he saw as NHS clinical and managerial complacency, rather than a means of implementing the economist's neo-classical dream or the right-wing politician's neo-liberal utopia. Indeed Clarke was to make it clear in 1989 on BBC Panorama that it was not himself but his opponents who talked about markets. He also scoffed at the idea that 'contracts' between Health Authority and GP 'purchaser' and hospital and community 'providers' be legally enforceable as opposed to an internal managerial tool—as a lawyer, he joked, he knew how lawyers could rip off the NHS.

Thus there were different tracks of political activity. One was 'low politics', or administration—the search for a solution to a mostly technical problem, albeit one embedded in the structural underfunding of the NHS. The second was the pragmatic search for an NHS reform that was elegant yet practical. The third was the ideological neo-liberal track—at first, confined to some advisers, think tanks and possibly to Thatcher herself, although she was a split political personality between traditionalist and pragmatist, on the one hand, and ideologue or fanatic, on the other.

The 1992 general election was the turning point for health policy. The Labour leader at the time, Neil Kinnock, later said that, had Labour won, they would have retained the 'purchaser/provider split' in the NHS. This is in part owing to the lobbying of Kinnock by some left-of-centre medics and public health doctors who supported the mechanism of the purchaser/provider split but not the market itself. Their view was that it would allow health authorities to make needs-based plans for public health and wider community services rather than just funding their own local hospitals.

Yet this seemed to be mistaken: firstly, effective planners and managers could more easily shape services they controlled rather than being bound in to finance 'self-governing' hospitals through contracts. Secondly, in

order to run a market, purchasers and providers had to be local, whereas the task of rationalising the hospital sector (where necessary) could only be effectively carried out by planning authorities with authority beyond the local: the biggest hospitals which contained the specialist services had regional catchment populations.

Thirdly, the so-called 'market' was actually used as a pawn of government diktat to enforce the priorities of the day—which, especially at the point of the electoral cycle before elections, usually lay in shortening waiting times through pump-priming hospital funding, raiding community service budgets more ruthlessly than the old District planning authorities had ever done.

Had Labour won in 1992, however, then the NHS—even if the purchaser/provider split had remained—would have retained the Griffiths reforms of 1983 while eschewing the 'permanent revolution' which became the default position by the 1980s. That is, the 'purchaser–provider split' would have been more a management tool to allow a separation of planning and management (Labour Party, 1992) than the harbinger of the permanent revolution which was to plague the NHS for (at least) the next 25 years.

In a pithy statement noting the move to the market from the much more reasonable 'general management' reforms of the 1980s, the late Gordon McLachlan, the redoubtable former Secretary of the Nuffield Trust who had ironically commissioned Enthoven to look at the NHS in 1984 which then led to the suggestion of an 'internal market', wrote to me in July 1993, 'I hope you are busy critiquing these disastrous reforms, including this "purchaser-provider c***", which obscures the real problem' (by which, he meant effective management). Roy Griffiths had counselled privately that another root-and-branch reform would divert attention from the longer-term bedding-in of his own 'general management' reform, and moreover that effective general management did not require 'the market'. This was a practical expression of my own view that the 'new public management' is not the first step of a neo-liberal journey unless ideologues make it so.

But it was too late. Mrs. Thatcher had responded to complaints about NHS underfunding by making attack the best form of defence. This was indeed her most habitual way of getting her way—attacking when others put their heads above the parapet rather than forging a lonely ideological path. For, despite her subsequent reputation, she had been cautious

in her earlier Prime Ministerial years about privatisation—both of key 'monopoly' industries and of key public services such as the NHS.

The government had been badly burned by the leaking of the cack-handed Central Policy Review Staff ('think tank') review of the welfare state which had proposed mass privatisation of key public services. Thatcher had disowned it, out of necessity and perhaps a little more: as with John Moore's subsequent inability to find a meaningful alternative to the NHS in 1988, she was impatient of ideology without substance. Yet when presented with an opportunity by the arguable naivety of her opponents, as perhaps with the miners' strike in 1984 (Moore, 2015), she was quick to pounce. Thus it was that the NHS Review was born (Paton, 1989) and 'the market' placed on the agenda. A double whammy of chance (the turbulence of the 'NHS winter' of 1987–1988 and then the availability of Enthoven's hitherto-obscure idea) had come to Thatcher's aid.

Rationality is not a judgement about ends (as to whether they are right or wrong) but a judgement about the coherence of ends and means. By this criterion, the Thatcher reforms were arational—not necessarily irrational, but less concerned with rationality in policy than with offering a political 'solution' to a 'problem' that was self-induced. The problem of funding which caused disquiet within the medical profession and the media was redefined as a problem of 'perverse incentive' (i.e. failure to ensure that hospitals' income reflected their workload in treating all patients irrespective of the latter's location). Ministers did not understand that this redefinition involved a sleight of hand, as discussed above. In any case, it suited them that the debate became one about efficiency. This allowed the market reforms to seem technically plausible while also furthering the ideological direction of travel of those Conservatives who were hostile to 'the state' and the possibility that the public sector could be successful.

As well as the opposition outside the government's tent of 'insider' groups and networks, there were quite a variety of options proposed to the Thatcher Review over the course of 1988. But these were all within the tramlines of market reform, and indeed the 'internal market' was one of the few options most compatible with a public NHS. The other options tended to emphasise the privatisation of healthcare financing, as with the perennial suggestions from the Institute of Economic Affairs, by then running a Health Unit directed by David Green. This former Labour councillor-turned-privatiser was to propose a private insurance

alternative to the NHS for years to come, latterly with Civitas. A similar phenomenon of privatisation-come-what-may could be found at the Adam Smith Institute, under the aegis of co-founders Madsen Pirie and Eamonn Butler.

Other think-tanks had a field day, especially the Centre for Policy Studies (CPS), set up in 1975 to provide an overt neo-liberal challenge to the-then Conservative mainstream by Thatcher's original mentor Sir Keith Joseph and former Marxist turned neo-liberal ideologue Alfred Sherman. As with Labour's reforms in the early 2000s, quite a few of the key players were former leftists who were applying their millenarian tendencies in the opposite direction having skipped the middleman of centrist pragmatism.

The CPS's leading light was David Willetts, former young Turk of the No. 10 Policy Unit, to which he had been recruited in 1983 by its then-head, right-winger John Redwood. Willetts later re-invented himself as the thinker of moderate Conservatism, post-Thatcher, but at this time he was an enthusiastic Thatcherite. Yet in the end, it was the more pragmatic Kenneth Clarke who sought to square the circle between ensuring that reform was not an anti-climax (by late 1988, the NHS Review was running into the sand and desperately seeking a solution) and yet which was capable at least in the theory of implementation in the real world of the NHS. Thus the 'internal market' became the chosen option.

The NHS Market in the 1990s: Politics Takes Over

To begin with, the internal market was a UK-wide policy, given its passage into law by the NHS and Community Care Act of 1990, eight years before devolution: it was implemented throughout the UK. But it was only in England that the market was developed enthusiastically. In Scotland and Wales, the organisations to operate the purchaser/provider split were created, and to a lesser extent in Northern Ireland too. But in all these three countries, there was less market behaviour, in the context of greater hostility to a market culture (and to Thatcherism per se, in Scotland and Wales). As a result, when (post-devolution) the market was abolished in these countries, the task was much less difficult than it would have been in England. Indeed, in the brief interregnum from 1997 to 2000 when there was an attempt to 'abolish' the market in the English NHS, the institutions of the purchaser/provider split other than GP Fundholding were retained.

In England, by the mid-1990s, the market culture had significantly infused the NHS and enthused at least an elite tranche of NHS senior managers. Budget-holding by general practitioners (the so-called GP Fundholding) (Glennerster & Matsaganis, 1994) not only 'took off' but also mutated into various experimental and developmental forms. These latter versions of GP purchasing, whereby groups of GPs rather than the traditional agency of the Health Authority made the contracts for services with NHS providers, indeed became the linchpin of the reforms after 1995 when they took on a different emphasis. This was a focus upon primary care purchasing (later 'commissioning') (Mays et al., 2001) as a means of service innovation and indeed allegedly of meeting long-standing priorities, rather than the more generalised mechanics of a market.

This new emphasis was in part down to policy innovation from the 'bottom up' i.e., as a result of initiatives from both GPs and local management, but more significantly it was a convenient means of keeping the reform agenda going when 'market competition' per se had begun to throw up at least conundrums for policy and management and arguably insuperable problems in the context of a public NHS.

In a nutshell: with both constrained resources and a policy objective of reducing hospital bed numbers, it made no sense—and was indeed impossible—to create the excess capacity required to provide market competition on the 'supply side'. One policy objective ('the market'), which was about process and structure rather than healthcare outcomes, was in conflict with another ('planning', albeit without using this word itself, which no longer dared speak its name in the ascendant neo-liberal era). Furthermore, if hospitals were to compete across the board, then how could they cooperate in offering complementary and specialised services?

This came to a head, among other places, in Sheffield in 1995, where the local Health Authority found the aggressive competition between the two main hospitals (long since merged into one Trust) unhelpful to say the least. Ministers found themselves supporting both sides of the argument, and Health Minister Brian Mawhinney, deputy to Health Secretary Virginia Bottomley (both close to Prime Minister John Major) was eventually forced to prioritise long-standing (and rational) planning objectives over the theology of the market.

This turning point led (in an echo of the Thatcher Review itself) at the central political level to a rather desperate attempt for a new 'big

idea' to disabuse any opponents of the reforms that they were labouring to produce a mouse. This is a political explanation for the emergence of 'primary care purchasing', sometimes called 'local purchasing' although of course, the latter did not necessarily include the same lead role for GPs.

The momentum for a new direction was aided by a burgeoning reform industry. Various jobbing academics and management consultants saw 'the reforms' as a continuing process and a moving feast of opportunities for influence and income. There was thus a well of new ideas for new initiatives, for which Ministers were grateful.

By 1997, when Labour won the general election with a manifesto which promised to 'abolish' the internal market, the market—such as it was—had produced equivocal benefits at a high cost. Some micro-level benefits were ascribed to the GP Fundholding scheme, and some system-wide productivity increases slightly higher than the norm since 1948 of 2% per decade were noted. But the latter occurred as central targets for output and waiting times were refined, as a harbinger of New Labour's target culture to come. But the main ambition of those non-Conservative supporters of the purchaser/provider split (hoping to change priorities) was thwarted, as hospital waits became even more the political order of the day than before. Interestingly ex-junior Health Minister Edwina Currie had noted in her diary as the reforms were mooted in 1988–1989 that what was blazoned as a major policy was in fact an unremarkable exercise in 'bean-counting'. This was quite prescient.

As reform took on its Maoist hue of continuous revolution over the succeeding years, the cumulative cost of all this became more of an issue than was ever acknowledged by mainstream politicians and even academics (whose evaluations of reforms tended to conclude glibly that costs were unknowable). My own partial estimations of cost, made conservatively, will be noted in Chapter 5. Here, we may remark that ironically given his later approach, the most effective scourge of the 'administrative cost' of the internal market from 1992 to 1997 was backbench Labour MP Alan Milburn, elected for Darlington in 1992 replacing right-wing Conservative Michael Fallon. After Robin Cook, Labour's razor-sharp Shadow Health Secretary from 1987 to 1992 moved on to other briefs, Milburn's questions in Parliament were pithy and rather damning.

The irony however was substantial. Partly as a result of his effectiveness in opposition as a scourge of the wastefulness of the internal market, Milburn became, the first, Minister of State at the Department

of Health in 1997 and (after a short interregnum as Chief Secretary to the Treasury) later Health Secretary towards the end of 1999, when the unfairly-maligned Frank Dobson left to become Labour's candidate for London Mayor. Yet as Health Secretary, Milburn oversaw Labour's own market reforms and indeed promulgated arguably the most expensive re-organisation to date in the NHS's history, from 2001 onwards. This dubious achievement was to be outdone later, however, by Coalition Government Health Secretary Andrew Lansley's car crash of a reform, the White Paper, Equity and Excellence (Department of Health, 2010), which led to the Health and Social Care Act of 2012. These later reforms are considered in the next chapters.

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CHAPTER 3

New Labour's 'Initiative-Itis': A Missed Target

Searching for a Narrative: The Third Way

Labour's 1997 general election soundbite concerning the NHS was 'reintegration without reorganisation'. By 2007, when Tony Blair left the Premiership, this could be rephrased in hindsight as 'repeated reorganisation without reintegration'. So what changed?

Labour's political aim in the general election of 1997 had been to persuade the public that there were only '100 days left to save the NHS' but also to persuade the NHS management community that not much was in fact going to change, or at least that change would be evolutionary, indeed incremental. Despite being out of office for eighteen years, Labour's policy was minimalist, reflecting Shadow Health Secretary Robin Cook's pithy statement back in 1991 that the best health policy for Labour was that 'we are not the Tories'.

There was moderate confusion in NHS senior management ranks as regards Labour's plans. Some of those who had become enthusiasts for peddling the market (or was it for pleasing their masters?) thought that Labour would reverse course, and were restless; others, more realistically, were ready to accept whatever fine-tuning was likely to result. An NHS Director was quoted as saying, apparently without irony or humour, when asked what New Labour meant for the NHS, 'Apparently purchasing's out and commissioning's in, but we don't know what it is yet' (Private communication).

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There was however an apocryphal truth in the London Director's recourse to the latest management jargon rather than healthcare reality. For Labour wanted to abolish the internal market yet not abolish it—as part of its Third Way 'triangulation' strategy more generally whereby it defined what it was against (two 'unpopular' things—Thatcherite 'deregulation' and 'Old Labour' statism) in order to spin an alternative to both. Blair had borrowed this approach through his transatlantic 'wonkathons' at which his policy wonks, including the young David Miliband (christened 'Brains' by Alastair Campbell, Blair's Director of Communications), cross-fertilised with President Bill Clinton's. In this context, the word 'commissioning' was ideal. It was Janus-faced: on the one hand, replacing 'purchasing', therefore pleasing opponents of the market, and on the other hand, allowing the 'split' between the commissioner and provider to remain, pleasing supporters of the market.

The Third Way in Labour policy generally was allegedly an alternative to the 'levellers' of post-war socialism/social-democracy yet also an alternative to the free-market laissez-faire associated with Margaret Thatcher (Commission for Social Justice, 1994). Applied to the NHS, it came to mean neither state hierarchy nor the market. This apparently therefore implied 'collaboration'. Academics now got hung up on the trendy concept of 'networks' as an alternative to the economist's 'hierarchies' and 'markets'.

Yet to see such approaches, or governance systems and mechanisms, as alternatives is naive. Networks are a virtually content-free concept, referring to webs of relationships, which may be organised using different incentives, if any) for different reasons, in different theories and practical situations. Equally, 'hierarchy' (for which read Labour's target regime) and markets may or may not be alternatives as opposed to complements, however tense the companionship.

Governance and the 'Purchaser/Provider Split'

But before the continual process of reorganisation got into full swing under New Labour, seemingly accelerating a process begun in the 1980s by the Conservatives, the first challenge in 1997 was how to govern the NHS in pursuit of key objectives. Rightly, Labour had identified quality of care as a priority. Labour's new Secretary of State for Health in 1997 was Frank Dobson, who had been a key member of Neil Kinnock's new-look Labour team in the 1980s but could by no means be described as

a Blairite. He was enthusiastic about the policy of abolishing the internal market, although realistic enough to joke that (quoting an anti-hero, the right-wing economist Milton Friedman) 'you need a candidate to beat a candidate' (Private communication)—one of Friedman's more acceptable if deliberately obvious statements. In other words, what was to replace the market?

This question had bedevilled Labour in the mid-1990s, and the national party office's attempts to think it through had been no more insightful than the then-Conservative government's Efficiency Unit's attempts in the mid-1990s to economise on the costs of the market. This unit was located in the office of the Deputy Prime Minister Michael Heseltine, and was known irreverently as 'Heseltine's bumf-busters'. Both failed to grasp the nature of the pre-market and post-market NHS in terms of the linchpin issue of contracting. Both sought to diminish the effect, which was high administrative costs, without understanding (let alone tackling) the cause, which was market contracting.

In Chapter 2, I pointed out that the market was initially seen as eccentric and an aberration from the NHS's way of doing business. It might therefore seem odd that replacing the market should seem so problematic. But New Labour was paranoid about seeming to 'turn the clock back'. Afraid of sounding 'statist' or, in the jokey sloganeering of the time, 'Stalinist', New Labour decided to keep the purchaser/provider split. Given this *fait accompli*, the challenge for the likes of Dobson was how to change the NHS culture without a structural catalyst so to do.

Preserving the split meant that some form of contracting would remain: yet the aim was to remove the high 'transactions costs' of the market, in particular those caused by costing individual patient care episodes necessitated by 'extra-contractual referrals' (ECRs)—the bugbear of both Labour's policy team in opposition and also the government's Efficiency Unit 'bumf-busters'. Both sides, to my astonishment, asked me in private meetings how ECRs had been handled before the internal market—seemingly unaware that, prior to the market's contracts, there could not have been 'extra-contractual' referrals!

Budget-Holding by GPs

What is more, another source of friction was General Practice Fundholding (GPFH), which was expensive, especially if one includes the opportunity cost of doctors' time. A major element of Labour's criticism

of the market had in fact been a criticism of *one aspect* of the market, rather than the market per se—that aspect being GPFH. It had been argued that patients registered with GPFH practices had an advantage over patients of traditional, non-GPFH practices, in that their doctors could make referrals to hospitals with money directly attached, and therefore could get quicker treatment for their patients—which had of course been the very point of the policy. A dual system was inequitable, but Labour initially decided to abolish GPFH rather than give all GPs budgets (which it did indirectly and half-heartedly after 2005, and which the 2012 'Lansley' legislation did more directly).

In other words, a two-tier system (some patients were registered with GPFH; some were not) was not an argument against GPFH per se, so much as an argument against the duality of some GPs holding budgets and others not. If GPFH was a transitional stage to all GPs becoming purchasers, then the objection might fall. This is a crucial point, as later reforms (under both New Labour then the Coalition government from 2010) sought to generalise alleged GPFH advantages across the whole English NHS.

Initially Labour abolished GPFH—indeed, by a sleight of hand, defined the market *as* GPFH and therefore claimed that the latter's abolition by 1 April 1999 represented the abolition of 'the market'. This of course left the wider market structures intact, although (from 1997 to 2001 in practice) damped down in operational significance.

The cost of 'primary care purchasing' (or commissioning, if one must) was an issue throughout all the market reforms over 30 years. GPFH was the first harbinger of this. A leading GP budget holder and Department of Health adviser David Colin-Thome later described himself humorously but with insight as a 'reform junkie' (Personal conversation): that small minority of GPs who were either 'reform junkies' or, more likely, entrepreneurially minded, could handle the cost to their time. Most GPs however had no desire so to do.

The same story has applied to all the successor schemes: 'Professional Executive Committees' between 1998 and 2005; 'Practice-Based Commissioners' after 2005; and Clinical Commissioning Groups from 2012. All these bodies were GP-dominated, but without reference to doctors in their titles so as not to offend the minority of other clinical professionals (mostly nurses) who might be on the various committees. For a review of clinical engagement in primary care commissioning, see Miller et al. (2012).

Primary Care Groups

Labour's abolition of GPFH led initially to Primary Care Groups. Before these could be instigated, the new government experimented with the sort of area-based GP commissioning groups inherited from the outgoing Conservative government's 'total purchasing' (Miller et al., 2012). But by December 1997, the White Paper, 'The New NHS. Modern, Dependable' (Department of Health, 1997) heralded the creation of Primary Care Groups within each Health Authority area. There were 100 Health Authorities in England, organised within Regional Offices, which had replaced the fourteen more independent Regional Health Authorities in 1996 as the central government paradoxically took tighter control of the 'market' agenda through making the regional tier a directly managed subsidiary of the Department of Health.

The primary care focus actually represented continuity with the final years of Conservative reform, when GP Fund-holding groups had merged both with each other and in some cases with non-Fund-holding GP practices, to form larger consortia. Such developments included the so-called 'Total Purchasing Pilot' (TPP) groups, which were given budgets by regions for all care, including emergencies, and which in hindsight bore some significant similarities to the GP (later Clinical) Commissioning Groups which emerged from Health Secretary Andrew Lansley's White Paper thirteen years later in 2010.

The idea of 'primary care commissioning', sometimes erroneously conflated in policy discussions with 'locality commissioning' (which may or may not be dominated by primary care clinicians), suited Labour at the broad level of symbolism, including keeping different factions happy. It should however be noted that, as New Labour's policy developed, the so-called 'primary care commissioning' was not actually GP-led but manager-led.

The new Primary Care Groups (and later the PCTs) were intended to emphasise, not least in their name, that hospital care should be considered a last resort, with the PCGs organising care as locally, and as much in the 'community', as possible. Why else would bodies holding budgets for all care, in which the hospital would always be the largest part overall, have the designation 'primary care' in their title?

We may note here another disadvantage of the 'commissioner'/'provider split' as it evolved under New Labour. In order to give a boost to what became statutory Primary Care Trusts (PCTs)

in 2001, the government gave them responsibility for a variety of community services and for particular care-groups such as the elderly. This was partly to continue what Primary Care Groups (PCGs), their non-statutory predecessor (or, pre-2001, alternative), had been doing. The idea embodied in the December 1997 White Paper (Department of Health, 1997) had been that primary/community-care based organisations would hold the budget plus the responsibility for non-acute care, contracting with hospitals (only) when necessary.

But a more pragmatic reason, born in 'low politics' (i.e. a political reason but not at the level of national political controversy, was that the new PCTs had to be given something substantial to do other than sign contracts to providers. The 2001 reform (Department of Health, 2001) should not be confused with the 2002 market reform (Department of Health, 2002). The 2001 reform was more about 'devolution to the frontline', which meant in practice trying to involve both local GPs and NHS Trust doctors (in hospitals and mental health units) in contracting. 'Devolution' did not logically mean a market, although Health Secretary Alan Milburn clearly saw the two as linked.

PCTs were in fact given services to manage which had previously been in community ('Self-Governing') Trusts in the 1990s as a result of the internal market, and they were also given some smaller hospital services which had hitherto been part of acute hospital Trusts. But a problem with this approach was that some PCTs developed a parochial mentality.

Another problem was a conflict of interest. Since the purchaser/provider split created a 'them and us' mentality between PCTs and hospitals, PCTs resultantly favoured their own small community hospitals and other providers over the separate hospital providers. They tried to be tough on hospitals in terms of performance expectations through contracts, but often oversaw low performance levels in their own providers.

NICE and CHI

More promisingly, Frank Dobson, Health Secretary from Labour's election in 1997 until autumn 1999, had rightly sought to focus policy on standards and quality. The creation of the National Institute for Clinical Excellence (NICE) and the Commission for Health Improvement (CHI) represented respectively the intended design of appropriate standards for care, including recommendations to the Health Secretary (as to which

medicines and technologies should be available on the NHS) and the facilitation of improved quality in hospitals and other providers.

Co-authored by Chief Medical Officer Liam Donaldson and Regional Medical Officer Gabriel Scally, the Department of Health paper, An Organisation With A Memory (Department of Health, 1998) launched 'clinical governance' in hospitals and other Trusts. The latter is essentially the corporate governance of clinical standards.

The NHS Plan, 2000

The NHS Plan of 2000 was a Janus-faced document emphasising both (in the government's mantra), 'investment' and 'reform'. Initially, it was the investment which was emphasised. Blair and Milburn sought to create a 'big tent' to launch it—nearly all the clinical and managerial 'great and good' co-signed the preface, and it seemed (indeed was) mostly about investment in new kit for the NHS, a kind of letter to Santa come true in good time for Christmas 2000. The backdrop had been a damaging political row following a *cri de coeur* from Lord (Robert) Winston, Labour peer and eminent embryologist, who had lamented in 1999 in an article in the left-of-centre New Statesman that NHS services were 'worse than in Poland', being underfunded and creaking.

Soon after, in January 2000, Blair announced on David Frost's Sunday morning TV programme that NHS spending was to rise to the level of the 'European average'. It was this which led Chancellor Gordon Brown to burst in on a subsequent private meeting being held by Blair and accuse, 'You've stolen my f***ing budget'. One suspects that Brown was also riled that his erstwhile comrade had also stolen his f***ing announcement: Brown liked personally to deliver any domestic largesse going, as he later showed when he commissioned the Wanless Report into NHS funding and later accepted its conclusions which he interpreted as endorsing both the NHS model and the need for more money (which he found by increasing that surreptitious tax, National Insurance).

The other side of the NHS Plan was 'reform'. It was stated in generalities at this stage, but a significant marker was put down in terms of the so-called 'concordat' with the private healthcare sector, which was now to be a partner rather than an awkward guest.

Targets

Next came governance by targets. Gordon Brown's dominant Treasury was virtually the executive office of the government for domestic policy, and its Public Service Agreement with the Department of Health was translated via the Department's own Performance Assessment Framework into detailed performance indicators for the NHS.

Regarding the meeting of targets and standards, the NHS's internal tiers inspected the 'key deliverables' (mostly finance and waiting times). In other words, it was at first the Regions, and then the Strategic Health Authorities, which did so. Regarding arm's length inspection, CHI now to inspect rather than facilitate (a move opposed by CHI's first Director, Peter Homa). CHI itself was to become the Commission for Healthcare Audit and Inspection; later renamed the HealthCare Commission (HCC). This in turn later became the Care Quality Commission when it took on social care also.

This approach was ironically much more hierarchical than the 'old NHS' deprecated in New Labour's self-serving narrative of the Third Way. (The 'first way' in the NHS, from 1948 to 1990, had allegedly been hierarchy and statism.) For between 1948 and the 1980s, formal NHS structures masked the reality that the centre articulated policy objectives in broad terms but then left the lower tiers to manage. It was partially after the Griffiths Inquiry in 1983 and then more substantially with the rise of the market in 1991 that we saw the centre (*i.e.* the Department of Health) strengthen its executive powers and actually *begin* to command and to control.

In the Third Way narrative, the 'second way' NHS-style had supposedly been the internal market (1990–1997). Of course the NHS market had borne little relation to the *laissez-faire* market economy depicted as the 'second way' more generally, beyond the NHS. Applying the narrative of the Third Way to the NHS was misleading; a rhetorical device which was either devoid of analytical content or indeed the opposite of the truth. For Labour's Third Way in the NHS ended up more centralist than its mythical predecessor 'ways'. This mirrored the Conservatives' myth-making that their internal market was about devolution: it was the opposite, as more central control was needed to steer the market than had been present in the pre-1990 days of regional and district management of the service.

In the NHS, the Griffiths reforms of 1983 onwards had begun the move to greater centralisation: they attempted to make the NHS more of a genuine corporate hierarchy, in the mould of public corporations, with a central head office and regional and lower tiers which not only 'reported up' but also incorporated the professions as never before. But this was always a compromise at 'street level' between NHS managers and doctors (nurses and other less powerful professionals were easier to corral).

Ironically if the 'new hierarchy' of Milburn had had the Griffiths structures without the market, then things might have been easier. But one of the problems with the new hierarchy, from 1999 onwards, was that it inherited the purchaser/provider split from the market era of 1991–1997.

Giving separate commands to purchasers (commissioners) and providers respectively became a major bugbear of New Labour's tenure from 2001 to 2006 and beyond. Not only did it make genuine collaboration between the PCTs and hospitals almost impossible; it also led to system disintegration when (see below) the NHS financial crisis of 2005–2006 hit home (House of Commons Select Committee on Health, 2006).

One of the innovations which had some merit but which sowed discord in practice was the system of 'star ratings' which operated from 2001 to 2005. Hospitals and also the 'commissioning' PCTs were rated from zero to three stars, with one incentive being greater autonomy for high-performers. This latter feature was however trivial, and much less important than the reputational effect of the ratings and indeed the 'blame culture' which percolated outwards from the NHS village to the tabloid press. For example, on one occasion, the ten Chief Executives of 'zero star trusts' were portrayed as handsomely paid turnip-heads on the front page of a well-known tabloid.

Irrespective of the merits and demerits of such whole-institution ratings, one of the biggest problems in practice was the fact that purchasers/commissioners (the PCTs) and providers (hospitals and mental health providers, primarily) were subject to a different set of performance indicators each—some indicators were the same for each, but many were different. This meant—for example—that a high-performing hospital which was capable of achieving a three-star rating depended upon its local PCTs funding it adequately so that its waiting times passed muster in terms of the target criteria.

So, there was greater centralisation, but it was often fragmented and incoherent.

Permanent Revolution: Blairite Restlessness

Labour's first few years emphasised quality in, and then increased resources for, the NHS. So why did Labour move away so quickly from these priorities in the name of structural tinkering? A sense of existential panic overtook those in New Labour who represented the New part of the title rather than the Labour part. This panic was not induced by quality, but by some rather crude data suggesting that overall NHS productivity, expressed prominently in 'waiting lists', had fallen slightly in 1997–1999.

As the now-exiled Dobson pointed out later, this apparently worrying indicator actually had improved before any new approach could have taken effect. Besides, NHS 'productivity', whether expressed through total workload ('Finished Consultant Episodes') or waiting times, has varied in both directions under all types of governance regime (trust; central command; the market), not least because it is such a dysfunctionally crude measure.

But for a restless reformer like Blair, patience was not an option. The period from 1999 through to 2005/6 witnessed continual reorganisation.

Shifting the Balance, 2001

In 2001 the 'Shifting the Balance' reform (Department of Health, 2001), the brainchild of Health Secretary Alan Milburn, created more than 350 Primary Care Trusts (PCTs) to replace 100 Health Authorities; 29 'Strategic Health Authorities' (SHAs) to replace eight regions; and 4 Regional Directorates of Health and Social Care to oversee the middle-tier of SHAs. This was an ill-thought-out and unwieldy reform, which Ministers soon came to regret. Shifting the Balance was announced by Milburn at a press conference appropriately enough on April Fool's Day in 2001.

The PCTs have been discussed above. The SHAs were neither fish nor fowl: they were too large to be local facilitators and yet too small to do regional planning; and another reorganisation, to reduce them to ten, occurred in 2005–2006. The Regional Directorates barely lasted a year.

New Labour's New Market, 2002

The New Labour market reforms were heralded in 2002, and were to consist in 'patient choice' with money following the patient in a scheme misleadingly called 'Payment by Results' (what was actually meant was payment by workload). It was correctly argued that under the internal market, money had not followed the patient but that the patient had followed the contract—with the purchaser (an NHS agency) rather than the patient deciding which providers were to be allowed for referral. The problem was the clash between choice and commissioning (see below).

Top-down targets were supposed to have been superseded by the market: Alan Milburn overtly claimed that the 2002 'new market' (as it was not called at the time) would obviate the need for him to run everything from the top. But targets grew stronger and more numerous—partly because the Treasury under Gordon Brown was not in favour of Milburn's market dabbling and partly because things were simply not joined up.

By 2005, all patients admitted to Accident and Emergency had to be treated, admitted or discharged within four hours; and there were increasingly demanding inpatient and outpatient waiting-time targets for elective operations. Yet one or more of the local PCT might be hovering around the one-star rating, without hope of meeting access targets at three- or even two-star level on behalf of its share of the hospital's catchment population. It might well be more interested in funding its own directly managed providers (community services, and/or small peripheral hospitals), or in achieving other targets—than helping the hospital achieve its ambition. In other words, performance management was not 'joined up' (Paton in Exworthy et al. [Eds.], 2011).

The NHS business model (if we may dignify it by such a name) under the regime of the 'purchaser/provider split' as run at this time was chaotic. The purchaser/commissioner resembled a shopper in a supermarket by-passing the till, pushing the trolley out of the door and making a dash for the car park, throwing what money he had out of his pocket as he went. End-of-year financial haggle was the name of the game, and 'contracts' were not worth the paper they were written onto the provider Trusts who were often simply not paid for their work (it was a little different for Foundation Trusts—see below).

In 2005, the policy of removing PCTs' 'provider' services from PCT ownership (to avoid the apparent conflict of interest and allow the

PCTs to focus on commissioning) was announced, although it was only accomplished from 2008 onwards. But this meant recreating the 1990s 'community Trusts' only with a variety of weird and wonderful names to disguise the fact that history was repeating itself.

After 2008, the newly refloated community organisations were to be designated 'third sector', i.e. taken over by social businesses and charities, in a rather futile premonition of David Cameron's Conservative policy of the 'Big Society' heralded by the Coalition Government after 2010—another short-lived fad. This 'third sector' fad never materialised in practice, hardly surprising to anyone other than 'Third Way' policy wonks who believed their own rhetoric about collaboration replacing both state and market.

The implementation of the new market only got up to speed after 2006. As it happens, this had been a watershed year for the NHS in terms of a loss of financial control throughout England. This was nothing like as severe as what happened after 2010 under 'austerity', but there was much less overt reason at a time of plenty. The English NHS was facing a deficit of £1.2 billion in 2005–2006—small change by comparison with later financial problems facing the NHS, post-2010, and especially post-Covid after 2020. But even so, a national deficit spread, albeit selectively, over the whole of England was quite an accomplishment at a time of plenty for the NHS.

Ministers were perplexed. They could not see that their contradictory policies amidst overall policy overload were responsible. Hospitals were ordered to cut budgets in order to fulfil their statutory obligation to 'break even' annually, despite the NHS now allegedly being on a three-year planning cycle, one of New Labour's meaningless boasts. Patients were therefore passed back to the PCT, so that care could be provided in the 'community' instead. But this was a euphemism for care denied; especially since the PCT also had to cut its own budget.

The costs of the purchaser/provider system, with its duplication of administrative functions on both sides of the fence as part of the contracting process, were a significant component of the 2005–2006 deficit. There were, to boot, far too many small PCTs, each with the full panoply of management structures and costs. Add to this the botched pay awards of 2004, the emerging payback costs of various PFI schemes and the fact that national priorities were snowballing, with money for each double and triple-counted, and we see that New Labour's policy regime was both overloaded and contradictory.

Health Secretary Patricia Hewitt had inherited the pressures leading to deficit in 2005, but these had been swept under the carpet in election year. Hewitt meanwhile had another 'little local difficulty' to sort out. Aware that her predecessor-but-one Alan Milburn had created far too many small PCTs in his ill-fated 2001 reform, Shifting the Balance of Power, she sought both to merge PCTs in yet another policy reversal and also to begin the process of making PCTs divest themselves of their in-house providers in order to remove the 'conflict of interest'.

Foundation Trusts

The Foundation Trust (FT) policy, a key element of the Blair–Milburn market, was part of New Labour's high noon in Blair's second term, when 'public service reform' was his domestic mantra, but it was also one of the symbols of New Labour's demise, also considered below, as it reopened Blair–Brown conflict and came to represent the excesses of Blairism in the eyes of the Brownites. The Brown–Blair compromise on FTs had emasculated the intent of the policy, in the eyes of Health Secretary, Alan Milburn—which was of course Brown's intention—and Milburn resigned in frustration in autumn 2003 to be replaced by loyalist apparatchik John Reid.

The Foundation Trust (FT) policy was—at a stretch of the sympathetic imagination—a rational accompaniment to, or component of, the new market announced in 2002. The idea was to create a new type of organisation, a lean, mean machine capable of competing effectively in a revived marketplace.

But there was a puzzle. Had not hospitals been made into 'Self-Governing Trusts', between 1991 and 1993 in 'three waves', to give them exactly the operating freedoms which the new FTs were supposedly going to have? Well, yes. But the arational part of policy was about signalling. This would concentrate minds wonderfully, it was believed. To be fair, it could be argued that the freedoms for 'Self-Governing Trusts' as advertised at the beginning of the Thatcher reforms had never been realised, and indeed that those which hadsoon whittled away as governments, and the Treasury, sought control.

What was absent from Ministers' minds in developing the FT initiative was any hard-headed analysis of why control was reasserted, in order to prevent recent history repeating itself. In truth, some of it was natural governmental control-freakery but some was a necessary attempt

by managers to keep the healthcare system coordinated, i.e. to do the implementation which did not interest headline-seeking politicians.

The FT policy was unpopular in the parliamentary Labour Party (many of whom, by no means all left-wingers, asked what Labour was doing relaunching the Thatcher reforms with additional bells and whistles). But this was Blair's second-term zenith (the fallout from the Iraq war had not yet seriously weakened Blair) and the policy was passed in 2003, with an admittedly narrow majority given New Labour's huge majority in parliament. Yet even this was only achieved when Brown—who had angrily opposed the policy in a long and detailed memorandum to Cabinet—called off his parliamentary dogs after a compromise with Blair which Milburn felt emasculated the policy—not surprisingly, as that was Brown's intention.

If this was the Self-Governing Trust story all over again, with the emasculation even before parliamentary passage this time, then what was the point?

The original intention had been quite radical. When asked in 2003 what the difference was between the Thatcher internal market and New Labour's reforms, Milburn's special adviser Paul Corrigan replied revealingly when questioned (at a private meeting with doctors on a leadership programme which I led in 2003) that 'they weren't serious; we are'. The aim was that FTs could raise capital from high street banks outside the Treasury process, decide their service-mix within certain limits and be governed outside the NHS structure altogether.

Another revealing answer to a question from the same group, meeting key decision-makers in the Department of Health, showed both the potentially radical nature of the policy yet also the confusion within the top echelons of the bureaucracy as to exactly what it meant. An hour apart, speaking separately, the Permanent Secretary and NHS Chief Executive, Nigel Crisp, and the Chief Nursing Officer, Sarah Mulally, were both asked if Foundation Trusts would be part of the NHS. 'No', said Mulally. 'Yes', said Crisp.

After the Blair–Brown compromise, FTs were no longer allowed to raise capital independently of Treasury limits; were restricted as to the private income they could raise to a small percentage of their whole income; and were clearly *NHS* Foundation Trusts, subject to some of the regulatory machinery passed down from the Department of Health to the Strategic Health Authority, including targets (although formally

they were regulated by Monitor, a new quango created for this purpose, which some wags suggested should be called (aping other regulators such as Ofwat and Ofcom) Offsick.

Their governance structure sent contradictory signals. On the one hand, they were supposed to be nimble market competitors. On the other hand, they were to have governing bodies which were composed of local stakeholders and citizens, who could pay one pound annually to become a 'member' of their local FT. The model in the minds of government advisers such as Corrigan was the Nationwide Building Society, and maybe the old friendly societies: these were non-profit but also, of course, private. There was a lot of naivety here. People in general did not want to govern, let alone help run, their local health service 'providers'; they paid taxes so that professionals (executives) could do that, and lay experts (non-executives) could oversee the process. New Labour sought to appeal to the older 'community self-organisation' ethos of pre-statist Labour, in an attempt to go beyond the quasi-neo-liberals among their advisers, in order to appeal to a wider Labour constituency.

Beyond this, Ministers and MPs actually believed their own rhetoric. In a reflection of Corrigan's remarks about New Labour being serious about their market reforms unlike the Tories, former Tory Health Secretary Kenneth Clarke (who had overseen the reforms instigated by his Prime Minister and old political adversary Margaret Thatcher), when asked what the difference was between Conservative health reforms and Labour's, had remarked that his lot weren't naive enough to believe their own rhetoric but Labour did.

The problem was that an FT could not be free to make unpopular decisions in a tough market with limited resources (e.g. to disinvest in services or change strategy) yet also be the creature of local activists or interests, i.e. risk having so many local stakeholders that it was 'stake-held to death'. This also mirrored what had been a problem with the original Self-Governing Trusts: the concept 'sounded' as if it promoted business efficiency but the reality was that it was easier to reconfigure district and regional services—according to changing needs, the search for better quality and also economies of scale—if hospitals were not preserved in aspic as formally autonomous 'self-governing' organisations with their own governing structure and, at least in the short term, a veto upon change.

Add in a third dimension—the need to collaborate both with other hospitals and with other NHS organisations to ensure that services developed appropriately—and the FT policy was an ill-thought-out mess. Later evaluations suggested that there was no significant difference between FTs and non-FT hospitals in terms of either quality or economic performance, and that any slight difference in the latter probably reflected the situation before FT status had been granted (a similar result to an earlier evaluation of the productivity of Self-Governing Trusts and directly managed hospitals in the early days of the 1990s internal market). Later data, from 2008 to date, on excessive hospital mortality, sought in the wake of the Mid Staffordshire Foundation Trust crisis, revealed a fair proportion of FTs on the danger list.

Additionally, implementing both the 'payment by results' tariff as a means of reimbursing FTs in practice (and other hospitals *in theory*) and the FT policy prevented 'integrated' reimbursement for 'integrated' patient care, as noted above. (We may now note that this became a reason for the Health and Care Bill of 2021 to include a removal of the rigid tariff.)

The Mid Staffs Foundation Trust

The FT policy came back to bite Labour in another way too. There was significant pressure from Ministers upon the Strategic Health Authorities to 'find' as many FTs as possible. There was a diagnostic process for such, intended for Trusts which had gained three stars in the star-rating system which operated from 2001 to 2005/6 but by 2005 extended to other Trusts as well. To turn down a request to go down this road if 'asked' was what Sir Humphrey Appleby of 'Yes Minister' fame would have called 'a brave decision' for a Trust Board. Among those launched into the process of Foundation Trust 'status' was the Mid Staffordshire NHS Trust which in four consecutive years had acquired 2, 3, 0 and 1 stars, respectively.

Add in the mission for the NHS as a whole and individual Trusts to break even, and indeed acquire a working surplus, in the wake of the NHS deficit crisis of 2005–2006. Add further the pressure to meet the prevailing government 'access' (waiting-time) targets. For many hospitals, this created pressure to restrict recruitment and cut nursing staff in particular.

It does not require huge ingenuity, or even hindsight, to see that such pressure would in turn put pressure upon quality. What is more, both

Monitor (the FT regulator) and the Care Quality Commission (CQC) were rightly criticised both for being myopic and having failed to collaborate in inspecting hospitals. Monitor was only supposed to recommend the granting of FT status if a hospital was excellent in the round—not just in terms of financial control. Its failure over Mid Staffs was spectacular, as was the quality regulator's. Even as a special investigation by the latter into Mid Staffs was beginning in 2008, the CQC's 'regular inspection' arm was accrediting it as good, and Monitor granted it FT status only days before the alarm was raised formally over alleged excess deaths.

There were three government-ordered reviews of Mid Staffs along the road to the Independent Inquiry called by the government chaired by Robert Francis QC—by the CQC; by the Department of Health's former Emergency Care Director, George Alberti (one of New Labour's 'Tsars', i.e. National Clinical Directors, in charge of emergency care); and by the GP David Colin-Thome. These all focussed upon the hospital itself, and missed a lot of the context, but the subsequent Public Inquiry, ordered by Andrew Lansley after Labour lost office in May 2010 and also chaired by Francis, rightly investigated the external relationships, i.e. the management, regulatory and supervisory environment (Public Inquiry, 2013).

The Private Finance Initiative (PFI)

Ironically, the PFI was much more central to New Labour's hospital rebuilding programme than it was under subsequent Coalition and Conservative governments. It had not always been thus. Labour had opposed the PFI in opposition, from its genesis in 1990 up to 1995, by which time Blair and Brown had become enamoured with it. That was worse than foolish, from a long-term perspective. When Labour lost the general election in 2010, the Conservatives gradually came to disown the PFI and by 2020 they were enthusiastically lambasting Labour for such a bad deal for the taxpayer and the NHS, which of course it was.

The PFI was not a *health* policy, but an *economy-wide* sleight of hand to keep public investment off the national accounts. There was of course a desire to avoid funding new hospitals and facilities generally through increased taxation or by 'printing money', i.e. making money available to banks and then the economy through cheap loans from the central bank. New Labour had after all tied itself to the Chariot Wheels not only of an independent central Bank of England but also of a promise not to raise

taxes. So if it also diagnosed the public sector estate as crumbling and neglected, which it was after 18 years of Conservative government (and indeed an economically straitjacketed Labour government in the 1970s), then it had to find another way.

Just as significant as the self-imposed rigidities of the PSBR accounting system was another reason for Labour adopting the PFI—the time-dishonoured desire to provide goodies while postponing the cost. This was a microcosm of New Labour's wider political economy after 2000, when its strategy was to rely on a global capitalist boom and the role of British banks therein to spread mortgages and cash to the not-so-well-off without taxing the better-off except through minor stealth taxation such as the increase in National Insurance to fund some of the NHS budget's expansion.

This fatefully advertised 'end to boom and bust' was another example of self-delusion by politicians, misinterpreting the entry of India, China, Brazil and the former Soviet-dominated Eastern block into the world economy as a kind of economic Kantian 'perpetual peace' or perhaps Fukuyama's (1992) ludicrous 'end of history'.

So the PFI was jam today. Unfortunately the postponed pain was even worse than had been suggested by the PFI's detractors—which included the former Deputy Director of the National Audit Office, who described the calculations which allowed the PFI always to seem a better deal than the 'public sector alternative' as 'mumbo-jumbo', going on to say that if the calculations came out wrong, you didn't get your new hospital, so they always came out right! By the time of the financial crash of 2008, when real interest rates became negative, what had already been a thoroughly bad deal became a ruinous deal.

In essence the PFI meant that, instead of the government using its large-scale power to borrow, private financial vehicles were created by business consortia to borrow on the open market in order to finance the new hospitals and other developments, and they were to be paid back over a timeframe of typically 30 years from the (annual recurring) revenue budgets of NHS hospitals. This meant that NHS commissioners' allocations to these hospitals were substantially reduced in terms of the costs of actually running services.

As well as borrowing at worse rates than any sensible government could have procured, substantial profit was written into the payback, and the assumed rate of interest, often higher than the market rate, was written into the contracts. After 2008, this rate of interest was 6%, as compared

with the zero or negative prevailing rates in the economy. Low interest rates after the financial crisis, and ten years later, the Covid pandemic, left the PFI as a millstone around the NHS's neck and a source of service cuts in order to pay big profits to those who held the PFI shares, which had often been sold on and traded on the stock exchange.

Piecemeal Policies: Rationality, Arationality and Irrationality

New Labour's policy went through the following phases: the initial rejection of the internal 'market' and the 'Third Way', i.e. collaboration, 1997–2000; the high noon of central targets, the 'new hierarchy', from 2000 onwards; decentralisation, 2001–2005; the new market, launched in 2002 and including the Foundation Trust policy of 2003, the patient choice policy and the accompanying tariff-based 'Payment by Results', codified further into the relaunch known as the 'Health Reform Programme' of 2005; a further reorganisation advertised in 2005 and implemented in 2006, to reverse (partially) the mess created by Milburn's 2001 decentralisation; and then New Labour's endgame under Gordon Brown, in which new policy was not forthcoming but the 'ethos' was less overtly enthusiastic about the market.

Health Secretary Alan Johnson, from 2007 to 2009, stated that market jargon had demoralised NHS staff; and Andy Burnham, his successor, then sought to steer a more 'pro-NHS' course than before, while still implementing the Blairite policies on competitive tendering for services and related issues.

Each phase can be seen as a part-rational, part-*arational* and occasionally part-*ir*rational reaction to what had gone before. The Conservatives in the 1990s had 'rolled out' first general policies to promote the market and then various specific 'primary care purchasing' policies. This is what started the ball rolling. When New Labour took office, there was a rational element to their policy. The extremely modest 1997 manifesto promises (a deliberate attempt to make promises believable and achievable) had included saving £100 million from reducing 'the market's' administrative costs and ploughing it into reducing waiting lists. There was also a reasonable judgement that the perverse incentives inherent in purchaser–provider relations had got in the way of both legitimate, indeed necessary, service planning and an emphasis upon quality of care as opposed to bean-counting.

An example of an *a*rational policy was the continuation of primary care purchasing, now called commissioning. Labour in opposition, in 1995, sought to combine what was hostility to the 'internal market' with a kind of unconscious, visceral belief that 'primary care' and/or 'locality commissioning' was also desirable. But there was no evidence which called for 'primary care commissioning', which was in any case often rhetoric rather than reality. It was simply becoming an orthodoxy, not least because of the 'insider' policy community which was, on the one hand, advising the Conservative government and the NHS community and, on the other hand, building bridges to an opposition which looked very likely to take power soon.

Next came the emphasis upon 'targets' to achieve higher productivity and achievement of waiting-time improvements. But soon targets were seen as unsustainable without wider system reform: Health Secretary Alan Milburn genuinely thought his subsequent system reform would bring the continuing achievement of targets on a more devolved basis, without the Health Secretary himself feeling he was holding the system up single-handed.

But it was very much a case of, 'targets are dead; long live targets'. Thus there were two new streams of policy emerging by the early 2000s, which were seen as related but in fact were conceptually distinct.

Shifting the Balance of Power in the Department of Health (2001) bordered on the truly irrational. As well as the PCTs, the SHAs were a minor disaster. As stated above, the SHAs were neither fish nor fowl. They were too big to represent natural healthcare catchment populations, yet too small to do the wider regional planning which all efficient public healthcare systems need. Additionally, it was unclear whether they were to be developmental organisations on behalf of their constituent PCTs and provider Trusts, or 'policing', top-down performance managers. The latter role, unsurprisingly, quickly crowded out the former. But even this was not well carried out—for the lack of legitimacy of the SHAs (not only unelected but centrally appointed) and the lack of formal powers to reshape healthcare within their boundaries (there were cumbersome procedures for reconfiguring services) meant that they monitored performance but could not manage it. The SHAs were, in short, a very expensive post-box, a clockwork mechanism in an electronic age, for transmitting central orders.

The four Regional Directorates were unwieldy, and were abolished within two years, in one notorious case even before permanent premises had been found. One Region meandered from North Staffordshire to

Hertfordshire and made no sense in geographic or substantive terms. Overall, Shifting the Balance was a monumental and expensive mistake, and should have been a serious discredit to Milburn, incredibly the erst-while hammer of the cost of the internal market in the 1990s. But such mistakes are below the waterline of 'high politics' (although not far in this case), in which policies reach the public eye and personalities' reputations are recycled, and so Milburn escaped scot-free to continue his reinvention as a 'radical' Blairite thinker.

The only rational explanation for Shifting the Balance is that it was intended to bring clinicians directly to the 'frontline' (the subtitle of the White Paper which launched it, continuing the prose which increasingly coloured such documents). But even this is to be charitable, for there was no evidence that the 'frontline' (whatever that in fact meant) was the right place for clinicians. If it meant being close to patients, it was a tautology. If it meant that doctors and other clinicians should be planning, contracting for and running the service, it was highly contestable. It might be 'politically correct' in the policy and management communities, but was wasteful of clinicians' time, better spent with patients.

Whatever the intent, doctors did not take over the 'frontline' of management. The new PCTs were run by traditional managers, and their 'Professional Executive Committees' (PEC), supposedly the locus for systematic medical input, were soon marginalised and seen as the metaphorical Friday afternoon chore for those doctors who had been bothered to be involved in the first place. In 2005, the demise of Shifting the Balance was announced.

When it came to the second prong of post-'targets' policy, the new market, a more lasting legacy was created. Self-sustaining improvement (also the slogan of the Lansley reforms eight years later) came to be seen as necessary, and a market driven by patient choice was seen as the route to this. The arational part of this new initiative lay in its origin—a separate but related panic about outcomes, just as a previous panic in 1999 had been about productivity, waiting lists and waiting times. Again, time had not been allowed for previous action to work its way through the system. And there was, as usual, no evidence that 'more market' was the answer or the 'solution'—not least because the question or problem was not articulated, if indeed there was one at all.

Not least in order to 'sell' renewed market reform to its supporters who had until recently celebrated Labour's so-called abolition of the market, New Labour now conflated the market with 'patient choice'. This was

not just cynicism, as the government naively thought that this was a new phenomenon for the NHS and also, even more naively, thought that their policies would make such choice a reality. In 2003, the Department of Health published 'Building on the best. Choice, responsiveness and equity in the NHS' (Peckham et al., 2011). It is also worth noting that there was now an explicit requirement to offer a choice of a private provider—opening up choice to a required number of providers (four or five, it was to become) including the private sector. This was based on the belief that the public sector needed a shake-up, a wake-up call, if you will. The direct engagement with overseas private companies by the government reflected a belief also that the traditional British private medical sector was stuffy and complacent, and itself needed a shake-up.

Garbage In, Garbage Out?

Labour was policy-rich but strategy-poor. Policies came piecemeal, poorly thought-out individually and incoherent collectively. The policy strands analysed above are classic examples of New Labour's characteristic approach to policy-making—policy-making by announcement following informal policy deliberations conducted on the No. 10 and Health Department sofas, the so-called 'sofa government' (Butler, 2004). But even this is not enough to explain the ever-changing, ever-accumulating policy. We must add in three additional factors—the fascination of the insider policy community (Ministers, Special Advisers, think tanks, academics, 'tame' managers and doctors) with the 'reform' agenda in general and 'the market' in particular; the susceptibility of a government—which never stopped fearing a revival of the Conservatives aided by the dominant right-wing media—to 'solutions' which signalled that Labour was not Left; and the interests and actual interest-groups created by the legacy of already-extant reform. All this mobilised bias to more reform, even when the latter became not only cyclical but circular.

Taken together, various factors enabled the conditions in England for the 'garbage-can' model (Cohen et al., 1972; Kingdon, 1997) to operate in policy-making: frequent 'decision-points', based on political 'panic' in the face of 'problems' requiring action; and a constant supply of 'solutions' from think tank land. Policy-making is not rational, although it may contain elements of rationality by design or by chance. Instead, policy is driven by the 'selling' of solutions to decision-makers, at times and for reasons which rationality cannot necessarily explain. Problems, 'solutions'

(i.e. policies-in-waiting) and politics are not related linearly, although politics is the source of decision-points and may be influential in shaping, if not defining, problems: problems may crystallise as the result of media portrayals, interest-group activity and their inter-relation, but at some stage, politicians will frame choices or make decisions as to when to create new policy, with varying degrees of autonomy from the agendas of others.

In the garbage-can model as commonly applied in the USA, the essence is lobbying by special interests. It should be noted, in applying it to the NHS, that the British context is less the lobbying of individual and diverse centres of power in a decentralised legislative system, as with the US Congress, and more the lobbying of central executive decision-makers. Furthermore, lobbying may be conducted to sell products or ideas—we may be referring to private healthcare interests lobbying for market reform of the NHS, but we are more likely to be referring to the 'sale' of ideas from think tanks et al. That said, the two are related, as 'idea factories' tend to be funded by commercial interests.

Meanwhile, we may note that, overall, the type of policy-making which has characterised reform—combining elements of rationality in an arational context—tends to create an irrational result: over time, change is not progress; 're-form' is not reform. For the raison d'etre for reform is different from episode to episode, and any rational kernel within the reform tends to be vitiated owing to an unfavourable context.

To take but one example, paying hospitals 'by results' could make sense in a system in which hospital care was part of an overall care which was 'integrated' around the patient's needs. But it was part of a policy to make some hospitals more autonomous than before—Foundation Trusts—and therefore created budgetary inflexibilities through the nature of contracts with such Trusts. Yet additionally, those hospitals which were not given Foundation status—which includes some of the most specialised teaching hospitals in England; by no means just struggling or 'unviable' hospitals—did not receive enforceable contracts, and so could simply not be paid by a commissioner if the latter could not afford to do so, or presented itself as such. The system was riddled with perverse incentives, as a result of reform being neither comprehensive nor adequately rational at each stage.

We should also note that a 'dynamic' picture of garbage-can policy-making does not just apply to the years of the New Labour NHS reforms but may also be used to analyse the provenance of previous and later (Conservative and Coalition government) reforms, i.e. not just 1997–2010 but the wider timeframe of 1988–2012. The process is described

here, however, as it was during New Labour's tenure that policies came so thick and fast, without coherent coordination, that the garbage-can model stands out as suitable. Previous and later reforms may have been just as harmful, maybe more so.

Stands Scotland Where It Did?

This was of course the English picture. The rest of the UK had long since moved away from governance by market. 'New' Labour was an English phenomenon. In Scotland, the English political environment more generally was absent. There was no question of the country being 'naturally Conservative', Tony Blair's abiding fear about England; there was no significant insider policy community like the 'London consensus' favouring markets; and reform had not progressed to the extent of creating 'blocking' special interests (e.g. fund-holding doctors, Trust federations et al.).

In Scotland, the internal market was abolished in two stages, and in Wales in three stages. In Scotland, devolution in 1998 produced a Labour administration with Donald Dewar as First Minister. Although Dewar was personally an erstwhile Cabinet Minister close to the Westminster government, the divergence between the governance of the different UK NHSs began, building on an already-separate heritage. The territorial offices of state for Scotland, Wales and Northern Ireland had always been responsible for inter alia health, not the London Department of Health which was the UK Department in terms of dealing with the rest of the world but the English (and in some cases Welsh) Department for the NHS and other domestic health policy.

In 1999, Scotland, having followed England (at this stage) in rejecting market culture on Labour's election in 1997, simplified NHS organisation further (NHS Management Executive, 1999; Scottish Executive, 1999). Scotland's NHS was overseen by Health Boards, the approximate equivalent of England's health authorities, although varying much more in population from Greater Glasgow at the large end down to the outlying areas. Each Board was to contain one acute Trust and one non-acute Trust, including mental health and various community services. GPs were to form advisory groups on a territorial basis to feed in advice to the Boards. Thus, while England after 2000 began to develop complex and expensive purchaser and provider agencies and relationships, Scotland applied Occam's razor.

In 2003, Scotland, still at that time run by Labour, removed the last vestiges of the UK Thatcher reforms, by abolishing separate statutory governing Boards for the Health Board, i.e. the planning function (what would have been called the purchaser or commissioner in England) and providers (Scottish Parliament, 2003). From now on acute and community Trusts would have management Boards to run them, separately from the overall Health Board planning and governance activity, on which they would be represented. But these management Boards would not be statutorily separate from the Health Boards, i.e. there would be no purchaser/provider split. Planning and management would however be distinguished.

This was in essence the UK model after the Griffiths general management reform but before the internal market; and was de facto what Labour had proposed at the 1992 UK general election, at a time when the Thatcher reforms were still seen as reversible in England—irrespective of what then-Labour leader Kinnock subsequently said.

Wales

In Wales, the process of 'de-Thatcherising' was more roundabout, or rather zig-zagging—occurring over the course of three reorganisations, with primary care in the end having only an advisory role, although with local primary care commissioners existing at earlier stages along the way. These different staging posts, unlike the more direct market abolition in Scotland, were reflective of changing approaches and arguably of less confidence in the robustness of the system. But the ultimate destination was similar: an end to the purchaser/provider split and governance through territorial unified organisations (Health and Social Services Directorate General, 2009; Welsh Assembly Government, 2009), called Local Health Boards in Wales.

Greer (2004) has rightly analysed the 'territorial politics' of UK difference. Moreover there has been a double-edged sword to the process of differentiation from England. On the one hand, the absence of Conservative hegemony in Scotland and Wales has enabled the equivalent in health policy of the football chant, 'Anyone but England', i.e. 'Anything but England ('s NHS reforms)'. Yet there has been definite nervousness that the English model might produce results unseen elsewhere. As a result, management initiatives in England such as targets to reduce waiting times have been aped elsewhere in the UK—with similar results.

For there had been a time early in the 2000s when it was argued that England had 'delivered' in those areas (Alvarez-Rosete et al., 2005), and some hubristically claimed that it was because of market reform. But their aping in Scotland in particular gave the lie to this (Connolly et al., op.cit.), as more significantly did the sober fact that English achievements in cutting waiting times predated the implementation of so-called market reform. Wales is more complicated, but—prior to 2010—a target regime had similar success there too, albeit to a slightly lesser extent probably because the regime was less draconian in command and control than England's so-called 'targets and terror'. After 2010, the real reductions in the Welsh block grant from the UK had a deleterious effect throughout the NHS there, although—as in England—local management may bear some responsibility for the more egregious scandals and shortcomings.

Overall, it seems that outcomes—and even processes, such as managing 'patient choice'—were similar across the UK. There was less consumerism, or at least citizen involvement, in England than the rhetoric suggested, and more elsewhere than the avoidance of such rhetoric would suggest. 'Choice' in England was heavily managed (Peckham et al., 2012), even after 2008 when it supposedly became wholly free.

In Hindsight: New Labour's Confused Governance of the English NHS

As it gave up its early belief in collaboration, New Labour settled upon a neologism—what we might call the 'new hierarchy'—hierarchy as central command and control rather than the traditional 'first way' hierarchy of tidy planning relationships. This new hierarchy cut out the middlemen—or rather, used them as agents of the centre. Ironically, this control-freakery was accentuated by the fact that the failure to abolish the purchaser/provider split had left the meso-level institutions of the NHS diffuse and uncoordinated. What was in theory an elegant market structure was in practice an anarchic fragmentation. And so the centre had to by-pass these structures (local purchasers and the like) with direct command to the frontline.

An early if subconscious intimation of this came in October 2000 when the new Chief Executive of the NHS, Nigel Crisp, was also appointed as Permanent Secretary to the Department of Health. This dual appointment drove a coach and horses through the 1983 Griffiths report's recommendation of a separation of the management apex of 'NHS plc'

from political control. At least it was honest and pragmatic: there was no longer to be a pretence of a divide between political command and managerial implementation.

But another consequence was to 'take out' the independent Permanent Secretary who was neither a political creature nor a manager and who could therefore give independent advice. This was to have consequences later (including during the pandemic, when the Department of Health was allegedly a 'smoking ruin')—for although the roles of CE and PS were later re-separated, the PS and his team did not regain the ballast, 'bottom' and salience of the pre 'managerial' era.

One element of the Griffiths approach remained—the need for professional management at the apex of the NHS. But instead of taking the NHS management board and its chief executive out of the civil service (with the mandarins now responsible for policy advice upwards, not management downwards as before 1983), the approach now was de facto to transform the Department of Health's civil servants: they would now be drawn from NHS management rather than the mandarin class or at least the civil service hierarchy.

The logic of the change was fully realised under Nigel Crisp's successor from summer 2006, David Nicholson—for Crisp, although by background an NHS manager, arguably had a mandarin temperament. Nicholson was however a fully fledged 'delivery' man: his self-perceived mission was not to counsel Ministers as to policy complexity but to reconcile policy directives with local financial solvency, with a blunderbuss when he thought necessary.

New Labour had in fact embarked on a canter through different governance systems (the inherited purchaser/provider split, 1997 onwards; collaboration, 1997–1999; targets, 2000 onwards; the 'new market', 2001–2002 onwards, reinvigorated 2005–2007) and accumulated new systems without removing the old as it went along, causing great confusion.

It might have been slightly better if they had acknowledged that different approaches to governance could co-exist, if not too many, and sought to analyse the compatibility or otherwise of different approaches. But that is not how politics usually works. What happened was one 'initiative' after another, with the new structures and organisations of each added to those of the previous one rather than any rational 'tidying' or rendering compatible of the different structures. What is more, these initiatives occurred in an increasingly 'pro-market' environment,

and therefore direction, which assumed that trust and collaboration were inadequate to govern public services—yet with much of the NHS's daily business reliant upon trust and collaboration to join things up, square circles and make things work.

Overall, then, in terms of governance, New Labour sought to move from trust to managerialism to the market, with a dash of hindsight thrown in, for reality was messier than that. Ironically, while it was wrong to see only one type of governance alone as 'the' answer, it was equally wrong to accumulate too many types. One was too little; three or four was too many. And by the mid-2000s, there were four extant approaches to governance: the inherited purchaser/provider split, which saw NHS bureaucratic agencies as the purchaser; the new market, allegedly driven by patient choice located at the GP referral; the new hierarchy which predated but continued with the new market; and the still-necessary and sometime-exhorted collaboration between 'partners' both within the NHS and beyond the NHS, especially with local government's social services.

In assessing New Labour's overall record on the NHS, it is undoubtedly true that many good things happened. But these were mostly as a result of significant funding increases, for which New Labour deserves credit. As a crude but useful generalisation, about half of New Labour's extra money improved services either in terms of access or quality. The other half was wasted—*not*, as the marketeers and privatisers would have it, because there was not enough market or privatisation, but because of the crippling cost of waves of redundant reform (most of which was 'market reform'). The official multi-part evaluation of New Labour's market reforms commissioned by the Department of Health's own Policy Research programme concluded that they had not done any direct harm and that the costs of the reforms were unknown (Mays et al. [Eds.], 2011). This was hardly a suggestion of value for money.

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CHAPTER 4

The Coalition Government's Blunder: The Lansley Reform

The Coalition government's NHS White Paper of July 2010, Equity and Excellence (Department of Health, 2010) was yet another example of self-congratulatory language attempting to conceal half-baked content. It was produced only two months after the 2010 general election which had made the Conservatives the largest party yet failed to produce an overall majority—hence the Coalition with the Liberal Democrats. Explaining this policy initiative can be separated into three sections: firstly, the way in which it did or did not build on what had gone before; secondly, the peculiar politics behind, and embodied in, the White Paper itself, and what became the tortuous road from that to the 2012 Act; and thirdly, the Health and Social Care Act of 2012 itself.

The Road to the 2010 White Paper: GP Commissioning and Market Provision

Labour had started by abolishing GP Fund-holding, announced in 1995, in the policy paper 'Renewing the NHS' (Labour Party, 1995) repeated in the 1997 manifesto, and accomplished in stages between 1997 and 1999. By 2007, its totem was 'Practice-Based Commissioners' (PBC): Health Secretary Hewitt claimed, in response to the valid criticism that Labour had gone round in circles, that this should have been the policy from the outset. But PBC was a damp squib which fell between the two stools of

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traditional NHS bureaucracy, on the one hand (since PBCs were accountable to the newly merged PCTs), and localism, on the other hand. Labour in other words had expensively reasserted the merit of GP commissioning without being clear about what it was meant to achieve. The message was the policy, in other words: it sounded anti-statist and New Labour-esque. Meanwhile the rhetoric of 'bringing decisions closer to the patient' was wheeled out yet again.

This latter aim had increasingly come to obsess Andrew Lansley. He was appointed Shadow Health Secretary in 2004 to replace the abrasive and unpopular 'privatiser' Liam Fox. Fox's main contribution to policy had been to propose tax allowances for the purchase of private insurance, a throwback to the debates in the early stages of the Thatcher Review in 1988, themselves a throwback to the review by Thatcher's first Social Services Secretary (then including Health) Patrick Jenkin of alternative systems to the NHS in 1981–1983 (McLachlan & Maynard, 1982). After the 2005 general election, Cameron became Tory leader and set about trying to 'detoxify' the Tory 'brand' in order to remove the impression that the Tories were the 'nasty' party. Cameron's predecessor Michael Howard was part of the cause of that impression, fairly or unfairly: he was the man with 'something of the night' about him, according to his deputy Anne Widdecombe when he was Home Secretary in the 1990s. Howard had however had the guile to see that Fox's approach to the NHS was politically unacceptable, and he replaced him with Lansley.

The latter was quite sincere in wanting to bring the patient, or at least what he saw as the patient's advocate in primary care, the GP, more centre-stage, and his starting point was this rather than privatisation. His sincerity gradually won him some plaudits in the NHS community. Yet he had not gone wholly soft, from the viewpoint of the Right: he also wanted much more of a market in provision. He was therefore seemingly an ideal choice to appeal to different elements of the party, and, post-Fox, to the 'NHS family'.

Yet this is a phrase which ignores to its peril the fact that many families are dysfunctional and divided; and Lansley may have overestimated his political capital as a result of a benign hearing from unrepresentative 'reform' minded GPs and that tiny minority of hospital doctors who were attracted by the ideas of the neo-liberal think tank Reform which had set up a branch entitled Doctors for Reform. (Some of these doctors—intelligent but naive when wading into political waters—did not realise that

Reform's agenda was hostile to the NHS, and that it faced in all directions as regards whether it wanted to replace, reform, or supplement the funding of the NHS.)

Although it was therefore misleading to think that he had given up on his pre-Health right-wing reputation, Lansley had worked assiduously to learn from the NHS over six years before becoming Health Secretary. By 2010, he was widely believed to have 'gone native', very much in tune with David Cameron's promise in the Conservative 2010 manifesto not to entertain any 'top-down reorganisation' of the NHS.

So what happened? How wrong could so many people be? Or rather, how could significant continuity in policy from New Labour's tenure, which indeed there was, be sidetracked by root-and-branch reorganisation?

The Conservative manifesto for health and the NHS in 2010 was not radical, and indeed boasting of such—promising 'no top-down reorganisation' of the NHS. The Liberal Democrats came up with their usual fare concerning greater democracy in health authorities (by now PCTs). When the election result led to a Coalition government with the Conservatives as senior partner and the Liberal Democrats as junior, a 'Coalition agreement' was drawn up in the weeks following the May election. This Coalition agreement led to a policy on the NHS which was both technically and politically incoherent, as explained in detail by Timmins (2012).

Prime Minister David Cameron and Nick Clegg, the Liberal Democrat Deputy Prime Minister, must regret not apprising themselves of the situation sooner and more acutely. Perhaps even more culpable however were the two colleagues asked to review emerging policy on behalf of Cameron and Clegg—Oliver Letwin for the Tories and Danny Alexander for the Liberal Democrats.

The rest is history. The self-contradictory Coalition agreement on health policy had to be rewritten, and Lansley seized his opportunity to produce what he really wanted without messy compromise as he saw it. Lansley has been described by Danny Finkelstein of The Times, also a Conservative peer and Lansley's former staffer at the Conservative Research Department, as a most unusual politician—a steamroller rather than a compromiser, and interested in policy rather than politics (ironic, given the reception afforded his White Paper.) As he beavered away, this was the stage at which Letwin and Alexander could have turned the signal

red. But the opportunity was missed and the White Paper was not only published before 2010 was out but also co-signed by Cameron and Clegg.

The White Paper proposed the total abolition of all agencies below the level of the Department of Health—the PCTs, the Strategic Health Authorities and the Regional Offices. The Department of Health management group (the NHS executive) would be wound up and an NHS Board established outside the Department—something which *had* been trailed in a 2007 policy paper from the Conservatives (Conservative Party, 2007) and also in the Conservative manifesto. This was an attempt to take politics out of the management of the NHS, a perennial chestnut regularly proposed over the years by the King's Fund and others, and of course tracing its pedigree back to the 1983 Griffiths Report.

Most of the NHS budget (at this stage, 80%, although later scaled down to 60% as reality filtered in) would go to GP commissioning groups, with PCTs wholly abolished. Putting GPs at the centre of the process—yet again!—had also been lauded, it should be said, in that same 2007 paper, but at the time those who paid attention (not many) assumed this meant either a reaffirmation of the primary care presence on PCT management executives or simply Tory endorsement of the 'Practice-Based Commissioning' which had become Patricia Hewitt's apology for a big idea at the fag-end of Blair's tenure.

Thus, in terms of governance and control, there would be, on the one hand, the Department of Health making policy overall and commissioning specialist services (about 20% of the budget, it was assumed at this stage) and nothing other than local GP groups, on the other hand. The latter would now be statutory, it was assumed, although whether and how this was possible was not made clear. Putting 80% of the NHS budget of about £100 billion at this stage in the hands of GPs who were not even NHS employees but independent contractors was strange, to understate the case, and hugely irresponsible.

Crucially, the most controversial aspect of the proposal was in terms of policy, for sure, the fact that an unnecessary reorganisation was proposed was controversial—one so big, according to NHS Chief Executive David Nicholson, that one could see it from outer space, directly contradicting Lansley's ludicrous protestation that it was not a 'top-down reorganisation'. But the privatisation, or scope for it, implied in the mandatory tendering for clinical services and, to underpin it, the removal of the Department of Health's statutory obligation to provide or secure a

service—opened the door to political rejection of the White Paper as it stood, given that the Conservatives were not in government alone.

Was any of this justifiable—not in terms of evidence, of which there was none; but in terms of judgement as to what had gone wrong in the past? Evidence for a new approach, to be fair, cannot by definition be available in advance. And to call for 'pilot projects' or experiments' is not always practical, a point made trenchantly in 1989 by Health Secretary Ken Clarke. He had scoffed when asked if he would 'pilot' the internal market, replying that he had no intention to have the BMA and the press crawling all over a high-publicity experiment.

The most valid criticism of Lansley was not that he failed to 'pilot' his policy but that he moved from a partially correct diagnosis to a disastrous prescription. The diagnosis had lots of insight. Let me put words into Lansley's mouth to make his rationale sound better than it was: *New Labour, in its perpetual itchy-fingered 're-disorganisations', had actually accumulated a very cumbersome set of commissioning institutions and had, moreover, complicated the purchaser/provider split. Both the 'one off' costs of each re-organisation and the recurring costs of the management arrangements were much higher than they need be.*

The House of Commons Select Committee on Health had produced two reports (2010, 2011) which pointed to the exorbitant cost of 'commissioning'. The Committee in its 2010 report quoted a York study of 2005 (Bloor et al., 2005) implying that the administrative costs of the NHS were 14% as opposed to 5% in the early 1980s, assumed to be not unrelated to the structure and content of 'reform', to put it mildly. The problem pre-2010 was that a succession of 'reforms', variously intended to promote technical efficiency, choice and more appropriate care (what economists might call 'allocative efficiency'), had been very expensive and in many cases failed wholly in their objectives. New Labour had confused permanent change and 'constructive discomfort' with business efficiency: it seemed that the Blairites had not recognised that stability and calm improvement was the hallmark of most successful business: yes, there would be times of rupture and change, but when necessary; not obsessively.

If the Conservatives therefore had wanted to build on Cameron's critique of Labour's NHS record, then they could have confounded expectations at this point. They could have in effect said: we believe in the market in general but there are areas of public service where the costs

outweigh the benefits. But in the end such a reversal of the orthodoxy since the internal market, that 'more market' was 'the answer', was a bridge too far. Instead, they made things much worse.

Shock and (Not Much) Awe

When the White Paper was published, the reaction was dismay throughout the English NHS. If the aphorism, that a fool learns from his own mistakes but a wise man learns from the mistakes of others, is true, then Scotland, Wales and Northern Ireland must have been feeling wise. For the English government, or rather the UK government administering the English NHS, had not even learned from its own mistakes. Previous reorganisations based on idealistic new policy visions had ended up losing the vision (or worse, discovering it led to dystopia) yet had also ended up costing the NHS dearly in terms of both money and effort. The latter, to make matters worse, was expended on reforming *structures* rather than tackling the *substantive* healthcare agenda. And now, the feeling was, here we go again.

The management community, not without its self-interest in cementing its myriad roles in the new NHS but in the main simply reacting to what it saw as a juggernaut of 're-disorganisation', was pessimistic but fatalistic. As ever at such times, the NHS lost a lot of talent. This time the aim was to reduce the number of managers, unlike (say) in 2001–2002, when the Shifting the Balance reform had caused the commissioning landscape to replicate itself like the fast-multiplying little brushes trying hopelessly to stem the flood in Disney's Fantasia. But although there were probably too many managers at the local level (even after the 2001 reform had been 'rationalised' by the 2006 reorganisation), the NHS could ill-afford the cost of the large severance packages, and a lot of talented managers moreover were lost at the now-abolished 'meso' level, *i.e.* the regional/strategic authority level.

Hospital doctors were generally dismayed, but pretty fatalistic too. The Royal Colleges and the BMA were opposed. But in the twenty years since the Thatcher–Clarke reform initiative of 1988–1990, the death of 'corporatism' had been confirmed: policy-making was seen even less now as a matter for securing agreement between the 'great interests' of business or management, trade unions or professional organisations and the state. As a result, the opposition of the medical profession, which had got a bloody nose from Ken Clarke in 1989–1990, maybe mattered less at first,

although when the Conservatives faced a rebellion by their Coalition partners, the Liberal Democrats, the resulting 'pause' in the legislative process atypically opened some doors for professional interests.

Other staff professional associations and trade unions, representing nurses, other clinical grades and ancillary workers, were wholly opposed—to the extent that it mattered. UNISON, the second largest trade union, was traditionally the main health service union, having emerged from a merger in the early 1990s of NUPE, COHSE and NALGO, and still is in terms of NHS numbers; but in recent years the spearhead of more thoroughgoing opposition to 'market reform' has come from UNITE, the country's largest union. These unions spearheaded the fight against 'Lansley'.

In GP-land, however, there was the usual small but vocal and nationally well-connected minority of 'reform junkies'. Even since GP Fundholding, some GPs had seized each opportunity to get involved in the succession of 'primary care commissioning' schemes, for reasons which varied from an altruistic desire to use greater autonomy constructively through a desire to control the money to the (probably dominant) desire to avoid control by others, from above (the government) or sideways (managers). This time around, Lansley's White Paper actually offered them—on paper—genuine autonomy, even more than in Fund-holding days, when the GPFH practices had been accountable to the Regional Health Authorities (Department of Health Regional Offices after 1996).

Unlike GP voices on PCT Boards, 'Professional Executive Committees' or (later) on Practice-Based Commissioning committees, this time the GP Commissioning Groups were to have Board status, with managers employed by doctors rather than (as hitherto, apart from the original fund-holding model) the other way around. This was attractive to those GPs who felt willing and able to hold the baby of commissioning.

But there was a catch—not a conspiracy by Lansley and the government, but a consequence of their failure to think through what implementation would inevitably mean, as discussed below. For GPs, for the first time across the whole NHS, would have to balance their role as patient advocate with making the sums add up. This was hardly the 'patient power' which Lansley had claimed to want. Meanwhile, the Royal College of General Practitioners, while sceptical about the policy, was prepared at this stage to give it a hearing. This changed later, when it became clear that the majority of GPs opposed it.

When the dismay about Lansley's White Paper, which had been picked up by the Chancellor George Osborne earlier than many others, percolated via the media right through to the whole Cabinet, it became clear by early 2011 that the dismay would translate into a failure to get the Health and Social Care Bill, based on the White Paper, passed in the Commons. For the government was a coalition—unusually, the UK parliament was not capable of passing the 'fastest law in the West'. Even had the Liberal Democrat leadership been willing to continue to support it, which they were not, the majority of Lib Dem MPs would not have been.

Cameron's Hand Forced: The NHS Future Forum

Prime Minister Cameron had to overrule an unhappy Andrew Lansley directly, and announce a 'pause' in the passage of the Bill. This was highly unusual, and was mainly the result of the fact that, equally unusually hitherto, there was not a one-party government with an overall majority, for the first time since 1977–1979, when Labour had just lost its small overall majority. There had not been a Coalition since wartime. This situation emboldened the Conservative sceptics in the House of Commons one of whom was Sarah Wollaston, a former GP who had been chosen as Conservative candidate through an innovative selection meeting open to non-Conservatives. She was a member, and later became Chair, of the Commons Select Committee on Health, and was a personable and sensible voice.

Cameron attempted to make a virtue out of necessity, arguing that, unlike previous administrations (it seemed he wished opportunistically to make the contrast with the domineering Thatcher), this one was prepared to listen. But nobody was fooled. Privately the government was gnashing its collective teeth, and—the more his colleagues looked into it—the more frustrated they became with Lansley whom they now realised could have pursued his more reasonable objectives without such senseless upheaval. So a committee was set up to review the legislation under the chairmanship of Steve Field, a GP with managerial experience in the West Midlands Region as well as some Royal College clout, and containing representatives of 'establishment laity' from the voluntary sector such as Steve Bubb, the Chief Executive of the Association of Chief Executives of Charities, and Bishop Victor Adebowale. This was the NHS Future Forum (2011; see Paton, 2012).

When the Forum reported, its recommendations were immediately accepted by Cameron, as a means of trying to 'move on'. But they were basically a mess, or at least a fudge whether deliberate or not, with warm words instead of analysis papering over the conflicts which had come to the surface as a result of Lansley's initiative. What is more, the new organisations which were proposed to 'coopt' some of the Bill's opponents would—if they meant anything; an open question—create a schlerotic rather than nimble NHS, and would 're-bureaucratise' what had at least been intended as an anti-bureaucratic reform.

This was principally because the Forum tried to have its cake and eat it in arguing that both competition and collaboration were possible. That may be true if defined in an arcane theoretical way, but the Forum moved from one definition to another in its analysis, failing to define both collaboration (was it between purchasers and providers, or between different providers?) and competition (was it between individual providers, for example, or was it between multi-provider 'integrated organisations'?) This meant that it did not make a coherent case for anything—not for abandoning competition (e.g. between hospitals); not for integrating services, i.e. ending the fragmentation between hospital and community Trusts; and not for competing 'integrated organisations'. This confusion was in the end useful to the government: it could continue with its plans but using a softer language.

If integration between different hospitals' complementary services, and between hospital and community services, was to be possible, then certain types of market reform—and certainly the type being proposed, both before and after the 'pause'—would have to be abandoned. But this was neither mooted nor did it subsequently happen. Monitor was the body charged with overseeing the fudge: instead of 'promoting competition' as in the Bill Mark 1, it was now to 'prevent anti-competitive practices' (sounds different but means the same) and yet also 'promote integration'. Quite apart from this having no real meaning in the Forum's fudge, Monitor was culturally quite unsuited to 'promoting integration'. It was staffed by mostly non-clinically qualified young competition hawks (Public Servant, 2012).

Not much of this mattered to the Cabinet, which simply wanted a face-saver which could then be handed over to the NHS Chief Executive and his team to make sense of. But a straw in the wind as to the nature of the hybrid which the Forum proposed came in the reaction of those non-Conservative figures who had been quietly, or not so quietly, sympathetic

to the Lansley vision. Former Labour Health Secretary Alan Milburn and Professor Julian le Grand of the LSE, an ex-Blair adviser, bemoaned the brake put on competition and the creation of new participatory bodies such as 'Clinical Senates' which would give representation to interest-groups. It seemed the compromise would alienate market reformers while failing to please opponents of the market and 'reform', in that it still enabled privatisation and still necessitated major reorganisation to create what were now to be Clinical Commissioning Groups and deal with the consequences of abolishing the PCTs and SHAs. The Forum had, through Bubb and others, links to the private sector—and while this came over in the Forum's report as support for the non-profit 'Third Sector', the proposed new NHS would have its front door opened to the new for-profit health players such as Virgin et al.

So what did the Forum propose? Principally, the new commissioners were to be 'clinical' (not only medical), i.e. to include the token nurses and others. Competition was not out, but it could not be allowed to crowd out integration. There were to be Clinical Senates to review local commissioning plans. And the local government Scrutiny Committees were to have a formal consultative, and possible veto role, on local health plans and especially service reconfigurations (which likely involved closures). Monitor, as we have seen, had a remit which was changed on paper.

The Lords Step Up to the Plate

But if the Cabinet thought the Bill could now be passed, they had reckoned without the House of Lords. There Labour's case was aided by the expertise of former Minister Lord (Philip) Hunt of King's Health, a former head of the NHS Confederation (representing the NHS commissioning authorities and Trusts) and its predecessor organisations. Labour was now joined by influential peers Baroness (Shirley) Williams, erstwhile leader of the Liberal Democrats there and former Labour Cabinet Minister, and Lord (David) Owen, former SDP leader and former Labour Foreign Secretary as well as Health Minister, as well as independents and independent-minded Conservatives. Ironically, on the other side, the Bill was supported by Labour's recent Health minister, Lord (Norman) Warner and one or two other Blairites.

So what was now the sticking point—other than general disillusionment with what the vast majority now knew to be an unnecessary reform,

but one which Clegg as well as Cameron knew could not simply be abandoned without debilitating loss of face?

Firstly, the Bill still did not restore the Department of Health's responsibility to provide a service under the NHS, which was missing from the Bill Mark One. This may seem arcane, but it was not just a quasi-constitutional or pedantic point.

To Lansley (who behaved almost robotically, it seems, in the light of criticism) and to those who believed in the full logic of the purchaser/provider split, removing the Department's role as 'provider' was simply to recognise that decisions as to services to be 'commissioned' were local decisions, achieved through contracts with 'independent', or at least self-governing, providers for whom the Department of Health was not responsible.

But this prissy view ignored the political and social realities of the NHS. It was and is a tax-funded service accountable to the citizenry via the government, which still—despite all 'purchaser/provider' theology—controlled it from the centre. It was and is therefore important that services are guaranteed by the Health Ministry. A Lords amendment was in due course passed, as opponents of the Bill in its current form negotiated with the government's spokesman Lord Howe and restored the Department's responsibility at least to 'ensure' that a service was provided. (Fast forward to 2021–2022: it is ironical that many of those who opposed Lansley's bill because it robbed the Department of Health of its power and responsibility also opposed the Health and Care Bill of 2021—which reversed Lansley's reforms—and bemoaned the granting of too much power to the Department of Health, which I discuss in Part II, Chapters 6 and 7. Such is politics!).

Additionally, the scope for privatisation was a major worry. The eventual passed Bill included limitations on the income which Foundation Trusts could make from private sources to 49% (still a huge percentage.) The government also claimed that the nature of mandatory tendering under the Bill now meant that the EU's single market 'competition' directive could not be invoked to the benefit of private providers, but this was doubtful.

Eventually the Bill was passed in 2012 (The Stationery Office, 2012) and the process of full implementation could begin (indeed had already begun.) But now the real trouble began, making the tortuous passage of the bill seem like a gentle preamble.

Making Sense of the Senseless

Soon the NHS 'bosses', as the press call them, realised that the question of competition was going to be a running sore. Was it competition for the treatment of particular conditions (e.g. 'the hip-replacement contract'); for services (e.g. orthopaedics in general); for overall specialties (e.g. surgery); or for whole-hospital contracts? Or for all or any of these, to be decided locally by commissioners? Crucially, if services were 'picked off' by private competitors, how would the hospital losing them stay viable—not just economically, but clinically (e.g. how would an Accident and Emergency department be competent if the hospital had no orthopaedic service?).

Even before Labour lost the 2010 election, Health Secretary (2009–2010) Andy Burnham had rightly defended the idea of 'whole-hospital' contracts, as the least he could do to maintain the coherence of a public sector in provision. But for even this modest brake upon the neo-liberal strain of Blairism, Burnham was pilloried by the former left-wingers seemingly turned neo-libs, Lord Warner and Paul Corrigan, his New Labour predecessors at the Department of Health.

One may go further: if competition was to be compatible with a coherent public service, then more than 'large contracts' were needed. Hospitals and indeed all services require integration—in the sense of cooperation around the needs of the patient who passes from one to the other, *e.g.* from the GP to a community service, into hospital, then a further 'tertiary referral' to a specialist hospital, then back to a community hospital, then home with a 'care package', e.g. planned home visits and outpatient follow-up. In the jargon, this is the 'patient pathway'. Simply to describe it suggests how dangerous to 'integration' piecemeal tendering and privatisation might be.

Moreover, if public money has been invested in public provision, then it is highly likely to be inefficient to sacrifice the value from continuing that investment, instead running down the public service in order to contract out. The latter sacrifices efficiency and effectiveness on the altar of market theology.

The next issue to confront those implementing what was now the Health and Social Care Act was the extent to which competition/markets and integration of care were in fact compatible. If care was to be 'integrated' in terms of the patient pathway (example above), then contracts

would have to be *either* let for the whole pathway *or* let to a 'lead provider' to manage the pathway.

If the former, then competition would be between rival regionally based 'whole pathway providers'—academically viable but seriously unaffordable in practice unless the NHS spent at Californian levels on healthcare.

If the latter (competition to be the 'lead provider'), which indeed was adopted for cancer and other services from 2014 onwards, then why should the *management function* for whole services be tendered and privatised when NHS 'leadership' had been such an expensive priority for more than 30 years in one guise or another? Either this development money had been wasted to an extent that Ministers should be deemed incompetent, or the agenda was ideological.

Regarding Clinical Commissioning Groups (CCGs), it soon became clear that these would bring down the whole edifice, through inexperience and incompetence, if they were not reined in and controlled from above. Yet again, a government had ignored the possibility that it was local commissioning per se that was the problem (Paton, 2010), and had to act to patch things up.

Since PCTs, SHAs and Regions had all been abolished, the only option was for the Department of Health to reinvent them as regions of NHS England (the renamed NHS Board), subdivided into Local Area Teams (LATs), soon renamed Area Teams (ATs). These were invisible to the public and yet made decisions on specialist services without accountability, as well as 'performance managing' the CCGs (BBC Radio 4, 2014). CCGs were thus subjected to the humiliation of losing the autonomy which had been the sole reason for the minority of enthusiastic GPs to get involved.

Thus CCGs became the 'poor bloody infantry' rather than the newly autonomous clinicians in charge. Those who ignore history (even the contemporary history of the last 15 years) are condemned to repeat it. This is what had happened to the small PCTs created in 2001, and even more so to their 'Professional Executive Committees' intended to put GPs at the centre of commissioning (Paton, 2006/2017); to the 'Practice-Based Commissioners' (Curry et al., 2008; and to all naive attempts at 'decentralisation' which ignored the need (practical not ideological) for meso-level (i.e. regional strategy, management and control). The iron law of ill-thought-out decentralisation in the NHS is that it devours its children and becomes its opposite.

Overall then, the latest version of the NHS presaged more fragmentation and indeed sheer mess, as well as and indeed as a result of an unnecessary loss of continuity.

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I referenced my adaptation of the garbage-can theory (Paton, 2014) in Chapter 3 above in explaining New Labour's trajectory of health policy. That approach can be extended to embrace the Coalition's handling of its inheritance from New Labour and the subsequent Health and Social Care Act of 2012 (Paton, 2016).

The UK central state, when a political party controls it with an overall majority, can pass legislation at the drop of a hat, sometimes without due diligence. That is why the UK legislative process has jokingly been called 'the fastest law in the West'. But even when the passage of legislation is tricky, in the rare times (as from 2010 to 2015) when one party does not have an overall majority, that does not mean that there has been due diligence as regards its content and coherence. Such was the case with the Lansley health reforms.

Furthermore, I have not examined public health within Parts I and II of this book, but the Lansley reforms weakened its structure and status, despite returning part of it to local government. This had a harmful effect when it came to the pandemic, as discussed in Part III.

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CHAPTER 5

The Cost of the Market

Direct Costs of the Market

There is much evidence that market structures in the NHS—the purchaser–provider split, commissioning or purchasing on one side and competition among diverse providers on the other—have cost a lot and delivered little, if indeed anything, positive—whether from 2012 to 2015, following the passing of the Lansley reforms into law; or from 2002 to 2012; or from 1991 to 1997.

Estimating accurately the total costs of market reform over 25 years is very difficult. But this does not mean the cost was not self-evidently huge. No official evaluation was undertaken of the first internal market (1991–1997), and the policy was applied inconsistently and in conjunction with other initiatives. There was an officially commissioned evaluation of New Labour's market reforms (Mays et al., 2011) but this concluded that the costs were probably unknowable. The reasons include *inter alia* the changing definitions of 'management costs' over time, the difficulty in distinguishing costs directly associated with market from wider costs (e.g. investment in information systems for clinical budgeting) and indeed varying definitions of the market (e.g. the purchaser/provider split per se versus the actual operation of competitive tendering with multiple providers).

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The absence of a definitive figure for the total or indeed for any of the individual NHS re-organisations in pursuit of the market helped 'pro-market' researchers to point to alleged benefits without reference to costs (Cooper et al., 2010, 2011)—a strange stance for economists of all people.

Let us consider the nature, scope and scale of the costs, if not a precise quantification. Market reform included:

1. preparations for, and investment in, policy implementation (non-recurring costs, but likely to consist in various stages);
2. management and leadership development through large-scale external consultancy (mainly non-recurring costs but with a recurring element);
3. creation of market structures—new institutions, such as Self-Governing Trusts, Foundation Trusts, GP Fundholding groups, Primary Care Trusts, Clinical Commissioning Groups, external regulators such as Monitor et al. (both non-recurring and recurring, especially as a 'market NHS' requires more purchasers/commissioners and more providers than an integrated, planned NHS requires agencies);
4. the significant costs of redundancy and changing employment arrangements;
5. pump-priming of new entrants to the market to make it 'competitive'. 'Market-making' has led to the subsidy of private providers to create competition where it does not exist, money which would arguably have been better spent on increasing and enhancing NHS provision; (mostly non-recurring);
6. development and maintenance of information required to run a market (to be distinguished conceptually from the legitimate information requirements of a modern health service) (non-recurring and recurring);
7. the transactions costs of the 'purchaser/provider split'—advertising, negotiating, contracting, invoicing, billing, monitoring contracts and resolving disputes whether legally or bureaucratically within the NHS, and hiring and employing additional staff as well as paying for the time of senior managers who are de facto drawn into the process; and

8. the major 'opportunity cost' of the resources devoted to the market overall—what else might they have been spent on, and what might that have achieved by comparison with the 'achievements' of the market. While opportunity cost is by one way of thinking a direct cost of expenditure on the market, it is considered below in a wider context—in discussing the amalgam of benefit and harm which may have resulted from the market.

When one takes three episodes—the 1990s' internal market; New Labour's market in the 2000s and the market further developed by the Coalition government's Health and Social Care Act (the Lansley reforms)—it is clear that the non-recurring costs run cumulatively into billions, as do the recurring costs, in that the market replaces unitary health authorities with a whole range of 'self-governing' agencies embracing both 'commissioning' and provision and the relations between the two.

Taking the more recent market reforms first:

The extant non-recurring cost of the Lansley reforms, (2010–2013) reforms was likely to be nearer £3 billion than the official figure agreed by Health Secretary Andrew Lansley as early as January 2011 to be £1.4 billion (House of Commons, 2011). That is because the official estimate left out—in terms of the categories in paragraph 22. Above—much of 1, 2 and 3; possibly 5; some of 6, and all of 8.

We should therefore note with incredulity claims by the government (before 2015) that the 2012 Act reduced 'management costs'. While an arbitrary cap was placed on such costs 'allowed' to the new CCGs, the re-creation by the backdoor of the meso-level institutions (Area Teams and the like), the panoply of regulation in the latest market and the substantial cost of compulsory tendering in the context of continuing expensive 'purchaser-provider' relationships are all continuing the high recurrent costs of the market.

To this, we might add the fact that the Clinical Commissioning Groups, whose management teams were composed of part-time GPs and a few administrators, were in no state to do 'commissioning'. As a result even the CCGs' core functions were frequently outsourced to private consultancies and other companies, as well as area 'support offices' for groups of CCGs, making a mockery of more than thirty years of investment in leadership and management by the NHS, from the NHS

Training Authority set up in 1984 to the Leadership Centre in 2001 and subsequently its successors. The leakage of talent through debilitating 'permanent revolution' did not help, of course, and one could be forgiven for sensing a conspiracy to make private management 'necessary'. Sadly the truth is arguably even worse: it was cock-up rather than conspiracy. But the consequence is expensive private commissioning.

Additionally, in the search for 'integrated care' (see Chapter 11, Prescription), NHS agencies—hospital Trusts, mental health Trusts, community providers et al.—were, by 2015 in different parts of England, being 'coordinated' by a lead provider from the private sector, which again costs a significant management overhead. Even more so in this case, one may ask why NHS 'leaders' are not up to the job of such a seminal leadership role in modern healthcare after billions of investment over decades; and, if they are, why they were not given the opportunity to lead.

It was claimed by some NHS England Regional executives in 2015 and 2016 that the 2012 Health and Social Care Act mandated that there must be a competitive tender for any services above a certain amount of value. But this ignored the fact that a 'new' integrated service (such as the ill-fated proposal for services for the elderly in Cambridgeshire, or the cancer service in Staffordshire) need not have been defined as a new service. It was essentially a new organisation and management of existing services delivered, after all, by the same NHS Trusts as before, only now beholden to, or even contracted to, a private overall manager. In such cases, obligatory tendering was more a case of risk-aversion in the face of possible legal challenges from potential private contractors. NHS managers are often risk-averse, as well as keen to please the political masters of the day—and it was no secret that the majority Conservative view included an evidence-free belief in the benefits of the private sector. But without the dysfunctional 2012 Act, of course, such defensive risk-aversion would not have been necessary.

The private sector, not surprisingly, reached its zenith in terms of NHS penetration in the years following the Lansley reforms i.e. 2012–2015. One should not underestimate, however, the influence of the Milburn market reforms which preceded Lansley's. Alan Milburn himself, on BBC2 Newsnight on November 23, 2021, reminded us of his view that 'partnerships with the private sector are the right thing to do'. He went on to say, in the light of the Health and Care Bill of 2021 (see Chapter 10 onwards, in Part II below), that '… it's a great irony…that

you have a right-wing [Johnson] government that is prepared to do less work with the private sector… than a Labour government in the past was able to do'. Milburn was right that it was an irony—which I examine in Chapter 6—but equally ironical (or rather brazen) was his failure to declare his own links with the private sector, after he had left office.

Milburn's own 'market reforms' when he was New Labour Health Secretary, incurred great waste. I estimated the non-recurring costs of reform during the period 2001–2008 at c.£3 billion (Channel 4, 2007; *Sunday Telegraph*, 2007)—with a major part of the cost incurred by the following elements:

1. Shifting the Balance (2001): the replacement of 100 Health Authorities (HA) with more than 350 Primary Care Trusts (PCT); Board/senior management replication, with the new PCT officers receiving similar remuneration to those at the previous Has—arguably £1 billion of direct waste, given (4) below;
2. Transfer of community Trusts to PCTs—employment/redundancy costs;
3. Market-making: the two tenders for Independent Sector Treatment Centres being prominent; also investment in out-sourced commissioning and support to commissioning;
4. Commissioning a Patient-Led NHS (Department of Health, 2005) (the 're-reform' given the disastrous consequences of Milburn's 2001 upheaval): the merging of 353 PCTs into 150 PCTs—major redundancy and transitional costs;
5. The subsequent development of commissioning from 2001 to 2008, culminating in major consultancy expenses allocated to 'World Class Commissioning', with the 'revolving door' between the Department of Health and the private sector again in evidence;
6. The divestment by PCTs of their 'provider functions', prefigured in (4) above but only implemented in 2008—reversing (2) above and creating 'community Trusts' all over again—on the grounds that a 'market' required health agencies to be solely purchaser or solely provider.

The conservative estimate of £3 billion does not include the non-recurring costs associated with Choose and Book or establishing the tendering and contracting involved in PCT contracts with provider Trusts

following the market begun in 2002. The recurring costs of these were of course substantial—see below.

Regarding the earliest (1991) market reforms, the scale and scope of the main initiatives only is indicated below:

1. replacement of unitary health authorities with separate purchasers and providers; triplication (at least) of senior management tiers and Boards, as unitary Health Authorities are replaced by purchasing Health Authorities, self-governing hospital 'Trusts' and self-governing community and mental health 'Trusts';
2. preparation for and development of Self-Governing Trusts—major management consultancy exercise;
3. preparation for and development of GP Fund-holding and purchasing alternatives such as 'Total Purchasing';
4. redundancy and other transitory employment costs.

The Nuffield Trust-funded research into the 1990s internal market (Paton, 1998; Paton et al., 1997) suggested that while cost had been considerable, outcomes defined in terms of three variables—degree of functioning market; more sensitive 'purchasing' to replace previous 'planning'; and changed priorities on the part of health authorities—had been negligible. Propper et al. (2008) found that where the market had operated in the form of price competition, surgical outcomes of certain types had worsened and quality had suffered. While Propper would argue that a better-designed market such as Blair's would remove perverse incentives such as these and possibly bring benefits, later systematic review of both the 1990s internal market (with price competition) and New Labour's market (in which prices were fixed) suggested that costs were much higher than any putative benefits (Brereton, 2010).

Arriving at a figure for the 'recurrent' costs of market reforms over time is equally difficult. There has been persistent instability and variation of market structure within and between the three eras of market reform since 1989; the research was not done on a large enough scale, if at all; the 'counterfactual' (ie a non-market NHS) is difficult to define e.g. what managerial infrastructure would it require even in the absence of a market. Yet the extra cost required to run a market is likely to be billions. The management costs (conservatively defined) of the English NHS in 2010 were approximately 12% of £100 billion by comparison with 4% of

a lower total in both numerical and real terms in the 1980s. Even if one-half of these costs are attributed to 'necessary' non-market infrastructure costs, then we can guess at recurring costs of the market being around £4 billion.

Market or Multiple Reorganisation as Source of Direct Cost?

It could of course be argued that the story of market reform in the NHS over 25 years from late 1988 to date overestimates the 'necessary' costs of the market. It is important to be fair and acknowledge—indeed draw attention to—the fact that much cost has been incurred by the fact that the English NHS has not been travelling in a straight line towards 'more market' over time. It has been a combination of zig-zags and loops, with the form of the market changed as governments have changed, and indeed within the terms of governments. The 1990s saw the Conservative government blow hot and then cold about the market. The New Labour government dismantled GP fundholding while retaining the purchaser/provider split; then instigated a radical decentralisation of purchasing /commissioning as the prelude to its own 'new market, which itself went through various mutations unconnected to the needs of the NHS. The Coalition changed the nature of its own market reforms even before they had been legislated (d'Ancona, 2013; Timmins, 2012).

Additionally, markets incur transactions costs (Coase, 1937; Williamson, 1997) between contractors yet integrated or planned services may incur high internal bureaucratic costs. It is an empirical matter as to which are larger, and which form of organisation is more appropriate, in different circumstances. It is important to enumerate, as well as 'waste' in planned systems as well as market systems, the necessary costs of a non-market NHS in terms of required managerial infrastructure. That is, it is important not to compare an imperfectly designed market with an 'ideal type' of planning or vice versa.

Yet there is much theory and evidence that markets are inappropriate for health-care (Hunter, 2013) especially where equity is valued. Even were we to subtract a major portion of the 'non-recurring costs' wasted over the years in setting up and dismantling short-lived market policies (as one structure gave way to another), there would still be high non-recurring costs remaining and recurring costs on a large scale. It is also

important to recognise that the political reasons for such organisational inefficiency are not going to disappear overnight. The market cannot be implemented in a vacuum, with a total absence of political noise, by a dictatorship of neo-classical boffins, and that is probably just as well. That is, what neoclassical economists may consider tampering with the market, politicians and citizens may well consider acting in the public interest. As a result, market reform is likely to involve stop-start', reversals and renewed effort. The costs of such cannot be assumed away as unnecessary if they are part of the legitimate functioning of the real world.

Wider, Indirect Costs of the Market

The direct cost of the market in terms of management and managerial transaction is one thing. And perhaps we should talk of administrative, not managerial, cost. For the cost has been not strategic but operational as it has consisted in servicing cumbersome duplication across 'purchasers' and 'providers' as a result of both the essence and frequent re- iterations of the 'purchaser/provider split', as we have moved from health authorities through the variants of GP Fundholding, 'Total Purchasing', Primary Care Groups, Primary Care Trusts Mark 1 (small), Primary Care Trusts Mark 2 (merged), Practice-Based Commissioners and now Clinical Commissioning Groups.

But even more significant are the 'opportunity cost' of the market and the wider costs of harm to the health-care system, respectively. The two are linked. Opportunity cost refers here to what might have been achieved if the resources consumed by the direct costs of the market. For example, what could have been achieved had the significant time given to devising and implementing the NHS market by policy-makers, senior managers and clinicians instead been devoted to other purposes?

Major substantive problems in health-care which have essentially been unsolved for decades, could have been addressed, such as: the appropriate mix between specialist 'super hospitals', local hospitals and community services; the pursuit of clinical safety and quality on a consistent basis and the diminution of inequalities in health.

This notion of opportunity cost (opportunities foregone) shades into harm to the system if and when the consequences of creating market structures and a market culture actually retard the solution of, or indeed worsen, major substantive problems. Some of the key leitmotifs of market reform, present in all three key phases of the market, are:

disintegration of both local and regional health communities into constituent parts without leadership of the whole, leading to dysfunctional and uncoordinated 'local health economies';
failure to consider at first how specialised services will be planned ('commissioned strategically') if planning is abolished and 'commissioning' devolved to local purchasers/commissioners: service concentrations and clinical networks have had to swim against the market tide;
reliance upon external regulation of individual market agents rather than internal (intra-NHS) strategic planning and whole-system performance management. Regulation and/or management of the market which has posed a dilemma: is its aim to damp down market forces where they threaten equity or go beyond the bounds of political acceptability, or the reverse—to seek to create competitive markets where, otherwise, 'market making' would simply turn a public service into a private monopoly? Policy here has been Janus-faced in all three phases of the English NHS market, primarily because clinical quality and economy require specialisation, concentration and complementarity whereas competitive markets require excess capacity.

Let us consider merely the first of these three issues.

In the first market, 1991–1997, it came to be recognised that, in reality, purchasers had the money whereas providers had the services, leaving an imbalance which led both to play games with each other rather than cooperate sensibly. At the outset of the second market, and especially in 2005–2006, this led to beggar-my-neighbour responses to financial crises.

My own study of the North Staffordshire health economy (Paton, in Exworthy et al., Eds., 2011) provided a case study of egregious beggar-my-neighbour policy. Individual 'marketised' health agencies—NHS Trust and Foundation Trust providers; Primary Care Trust (PCT) purchasers—all sought to break-even, or avoid worse deficits, at each other's expense. Primary Care Trusts in particular sought to 'dump' costs at the hospital door, and the GPs within the PCTs' boundaries referred patients to hospitals in large numbers effectively transferring costs of treatment away from GP budgets and onto PCT budgets. Hospital cuts were made by providers on the assumption that community services would

be commissioned to replace them; meanwhile, cuts made by purchasers (PCTs) reduced community services.

From 2013 through to 2015, we saw yet another crisis in emergency care, as Accident and Emergency departments all over England were pushed to breaking-point. Clinical Commissioning Groups are powerless to prevent this, as they had to pay Foundation Trust hospitals legally for care which leaves them unable to invest in the alternatives. If they avoided paying hospitals for the workload which ends up at hospital doors, then they simply push the hospital into financial crisis. This was a consequence of the market in that separate purchasers and providers sought to 'dump' patients, costs and problems on each other.

Yet ironically the point of the 'purchaser/provider split', to those of its advocates who were not ideological market reformers, had been to allow purchasers to prioritise care in the community, in order to obviate hospital admissions where possible and to reduce lengths-of-stay where admission had occurred. The problem of 'beggar my neighbour' behaviour in the marketplace, in the context of a worsening financial plight, was in the end one of the main reasons for de facto abandoning the market from 2015 onwards—after twenty-five years of fiddling while Rome burned. By the time the pandemic hit in early 2020, the NHS would have been in even worse shape to handle it than it was if the market had been in full swing.

* * *

In the long run, the 'narrative' of markets was perhaps bound to run dry. But as Keynes remarked, in the long run we are all dead. It took two catalysts to force this outcome a little sooner. Firstly, and less significantly, the Lansley reforms pushed absurdity too far, especially when the second, more important, catalyst had time to hit home. This was the worsening fiscal climate for the NHS which by 2015 *forced* a more rational approach to running services onto the agenda. This began without legislation, but subsequently led to the Health and Care Bill of 2021. This is examined below in Part II.

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PART II

A Corrective Counter-Revolution

Beginning modestly in 2015, we have had a new direction in the NHS, first prefigured in the NHS Five Year Forward View and then amplified by various local initiatives with central encouragement and official funding for development. These culminated in the Health and Care Bill of 2021 (close to Royal Assent and soon to become the Health and Care Act of 2022, at the time of writing in February 2022) which built upon a White Paper in February 2021. That in turn had been based upon a 'consensus' paper produced from within the NHS in September 2019, soon given the green light by the government of Prime Minister Theresa May.

Check for updates

CHAPTER 6

Counter-Intuitive Tories: The Health and Care Bill

A Sea Change

It was ironical that Andrew Lansley—who had after all become committed to a tax-funded NHS as opposed to an alternative mode of financing healthcare—went down in contemporary history as more dangerous to the NHS than his successor Jeremy Hunt. The latter had after all co-authored an earlier publication calling for those who could afford to do so to save through 'health savings accounts' for healthcare needs, then to be purchased from providers in the marketplace whether public or private.

Hunt had thus been associated with alternatives to the NHS model of financing healthcare altogether, rather than being interested in schemes to 'marketise' it and open the door more systematically to opportunities for private provision, as was Lansley. One paradoxical result of this was that Hunt was not wedded to the latter: when he came to embrace the NHS model as Secretary of State, he was more capable of pragmatism as to its organisation than Lansley. Unfortunately his mishandling of a major pay grievance by junior doctors which came to a head in October 2015, when he was accused with some justice of being devious and economical with the truth, temporarily squandered this capital.

Over time, however, and certainly in hindsight, it became clear that Hunt was a pragmatist who was not very interested in the theology of

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market reform. It is interesting to note that, after he replaced Andrew Lansley, choice as promoted by Milburn or Lansley almost disappeared from the health policy discourse in England.

'Simon Says'

Arguably more significant than Hunt's appointment was the emergence two years later of the new Chief Executive of NHS England. This was Simon Stevens, who took over in April 2014 from the much-maligned David Nicholson. Stevens was a smooth-tongued former President of the Oxford Union (and college contemporary of one Boris Johnson) who had become an NHS management trainee and then an NHS manager.

He had also been a Labour councillor, prior to becoming special adviser to Frank Dobson, Labour's first Health Secretary after 1997, then to his successor Alan Milburn, then to Prime Minister Tony Blair. After this, his career in the USA with United Health meant that when he came in as NHS Chief Executive, he had an independent source of authority: he was not just a promoted NHS regional manager, as had been all his predecessors in the age of the market—Duncan Nichol, 1989–1993; Alan Langlands, 1993–2000; Nigel Crisp, 2000–2006; and David Nicholson, 2006–2014. His successor, Amanda Pritchard, appointed in 2021, was also a career NHS manager.

Stevens was successful in persuading Hunt and the government, in the run-up to the 2015 election, that £8 billion would have to be found—both to give the NHS breathing-space, and also as the minimum conceivable as part of the £30 billion agreed to be needed and of which a massive £22 billion would still be required to come from that lovely euphemism (or is it oxymoron?) 'efficiency savings'. (Often promoting genuine efficiency, as opposed to economy or death by a thousand cuts, costs money, especially in the short term.) It is difficult to imagine Nicholson or indeed his other predecessors being as effective in 'persuading up' as opposed to transmitting orders 'down'. That said, the overambitious statement on efficiency savings of £22 billion promised by Stevens did let the government off the hook somewhat.

Moreover, Stevens (although he had been an enthusiast for market reforms after 1999, dismaying his first political boss, Frank Dobson) was at heart a pragmatist, and now those neo-classically based, academics who had seen him as their champion were equally dismayed to find no reference to markets at all in Stevens' first major document from

NHS England, the rather clunkily named NHS Five Year Forward View (Department of Health, 2015), in early 2015.

This was the beginning of the move (back) to integrated local health economies, albeit couched initially in market jargon where necessary. De facto, the rigidities caused by the theology of the Lansley reforms began to be ignored where legally possible. A most egregious example of market theology had been the idea that the Clinical Commissioning Groups (CCGs) should not be allowed to 'commission' primary care, as it would imply GPs commissioning from themselves. But evaluation of the previous scheme most similar to the CCGs—the Total Purchasing Pilots in the late 1990s—had a shown that, while in fact GPs were neither particularly interested in nor therefore good at commissioning in general, primary care and local community services was a partial exception.

The answer was surely therefore to solve the conflict-of-interest by making the new commissioning groups authorities which were wider than merely GP bodies. This would have solved also a major problem with the new CCGs: whereas with Health Authorities in one form or another (1948–2001) and PCTs (2001–2012) the GP had remained at least in some senses the patient's advocate, as the ultimate 'rationing' decisions were taken by management authorities, with CCGs, the GPs themselves were the ultimate rationers. This was a conflict-of-interest much more serious than Lansley's market conundrum.

Now, post-Lansley, the conflict-of-interest would just have to be ignored. It was ludicrous that GPs had to commission hospital services, which most of them were no good at, not interested in doing and would need substantial long-term investment in order to do adequately (Malbon et al., 1998; Thorlby et al., 2011) and yet could not commission primary services, which had to be done by NHS England i.e. the Area Teams in practice.

So new 'pathfinders' were set up to 'pilot' CCGs' commissioning all services except specialist ones—in other words, to get back to doing what had previously been done by all health authorities since the abolition of Family Practitioner Committees in 1990 and the subsequent absorption of their temporary replacement, Family Health Services Authorities, into the general Health Authorities. Along with these pathfinders came other pilots to bring together NHS and social care 'commissioning', building on the ubiquitously quoted local so-called success stories which the King's Fund, Nuffield Trust and other outside (but now increasingly 'insider') bodies had been publicising for years.

Thus we were seeing the reining in of the market obsession. This should not be overestimated: the expensive PFI remained, as did the unwarranted assumption that it was necessary, or at least better, to 'outsource' major contracts to 'integrate' care—for example, in order to bring together hospital departments, community services and care providers for cancer patients. But the idea of the market as the engine of the system—as opposed to the feather-bedding of private firms such as Virgin—was in decline by 2015.

The Health and Care Bill

The NHS White Paper, published in February 2021 after a leak, was entitled Integration and Innovation (Department of Health and Social Care, 2021) and set out the government's proposals for a new Health and Care Bill intended to supersede and reverse key provisions of Andrew Lansley's 2012 Health and Social Care Act. The Bill itself was then published on 12th July (UK Parliament, 2021).

The Bill gave a statutory basis to 42 Integrated Care Systems which were expected to cover all of England by April 2021. ICSs were legally to assume the commissioning function which previously rested with Clinical Commissioning Groups, themselves abolished. ICSs would also have statutory responsibility for providers through their overall Board, and the decision-makers in ICSs would include representatives of hospital trusts and GPs, so that the organisational separation between commissioners and providers—the purchaser–provider split—legally disappeared. Providers and commissioners would therefore work together in planning services for an area through strategic plans for their respective areas within budgets set by NHS England.

NHS England absorbed NHS Improvement (created originally through a merger of the Care Quality Commission and Monitor) and also the NHS Trust Development Authority, which was responsible in the market/purchaser–provider split era for NHS Trusts (those hospitals, mental health services and community providers which were not Foundation Trusts).

ICSs were freed from the legal requirement to put all services out to tender, and the Competition and Markets Authority will no longer have the power to approve or block mergers between NHS trusts. The new Bill also gave the Secretary of State power to give general directions to the Chief Executive of NHS England (a power which was removed by the

2012 Act), and specific powers to intervene in 'reconfigurations' of local services, such as mergers between trusts.

It should be noted that Integrated Care Systems evolved from a variety of experiments in integration at the local level (what tended to be called 'place-based' initiatives), on the one hand, and area-wide coordinating mechanisms, on the other hand. These were widely documented by the King's Fund (see for example Ham et al., 2016; King's Fund, 2015, 2016, 2017) and Nuffield Trust (see for example Kumpunen et al., 2019) as they developed over five years or so, with the staff of these organisations heavily involved in consultancy, development and evaluation work around what were in effect nationally prescribed-prescribed local initiatives. And not surprisingly, these 'insider' think tanks were keen to point out that the new developments were not about privatisation (Dayan & Buckingham, 2021).

This uneasy tension was in the time-(dis)honoured tradition of the NHS, in which localism was never what it seemed. These formed the building-blocks for what now became a more ambitious national initiative. As ever, localism was swallowed by centralism. This is *not* a criticism of centralism; it is a criticism of holding out localism as a false prospectus which leads to inevitable disappointment and incidentally waste of resources (time, energy, enthusiasm, money) along the way.

The various 'informal' but formally catalysed organisations which had been growing in salience in the NHS in the years since they had been 'mandated' by the NHS Five Year Forward View (2015) had a confusing range of names drawn from the arcane managerialist argot which had infused the NHS for thirty years. But, more benignly, they were about collaboration: this was, on the one hand, between different providers (acute and community Trusts; acute-acute collaborations; community-community collaborations etc.) and, on the other hand, commissioners and providers (some if not all in an area covered by the commissioner, which was itself, by 2020, likely to be an amalgam of what had originally been smaller Clinical Commissioning Groups. Like PCTs before them, CCGs had grown bigger out of logistical necessity (planning services for a large enough catchment area) and therefore their number had shrunk.

The latter, area-wide coordinating organisations, were originally called Sustainability and Transformation Partnerships (STPs) before being rechristened Integrated Care Organizations via the *Americanisant* title of Accountable Care Partnerships or Organizations. These were motivated centrally by the Arctic economic climate facing the NHS from 2010

onwards, consequent on both the banking crisis and resulting fiscal crisis of 2008–2009 and also the formation of a Conservative-led Coalition government and then, after 2015, Conservative governments.

STPs were rightly seen as organisations making cuts to services, cuts disguised in managerialist mumbo-jumbo. But this does not alter the fact that—faced with financial crisis and the cold, hard fact of budget stasis—the NHS simply could not afford the wasteful ongoing costs of the market. If budgets were to face draconian cuts (in real service terms, irrespective of government rhetoric at the time) better at least to maximise the benefit to patient care from the available reduced resources. To put it another way, STPs were born in misery, but they (and the local integration initiatives and experiments) put in train a process towards a more rationally planned NHS in England.

We should however be sober about the prospects for integrated care to reduce costs whether in bad times (the catalyst for abandoning wasteful markets) or good times. Evaluations tended to show that savings achieved through less hospitalisation, shorter lengths of stay et al. did not materialise. Explanations tended to be sought in technical, process-type reasons (see for example Kumpunen et al., 2019). But integrated care—however beneficial if 'done' well—is not likely to be about savings, as it is likely to uncover unmet needs as well as (at the most optimistic) achieving more effective care more economically. What it should be about is better care with reduced unnecessary management costs, the latter achieved by removing wasteful market mechanisms and their management (actually administrative) consequences.

It is not fanciful, at least not as instructive hyperbole, to see the English NHS's 42 ICSs—the fleshed-out progeny of STPs et al.—as not dissimilar conceptually (despite 50 years of new jargon and management-speak disguising the similarity) to the Area Health Authorities (AHAs) introduced by the 1974 NHS reorganisation which followed the 1973 NHS Act (legislation.gov.uk, 1973). They will be geographical entities, like their 1974 counterparts—albeit achieving their geographical coverage by 'merger upwards' rather than central fiat. In this sense, they will not be in any way like US HMOs, the cry of various well-meaning but misinformed activists on the Left of politics.

Instead of 14 Regional Health Authorities then, it will be ten regional offices now; 42 ICSs instead of 90 Area Health Authorities; within the ICSs, as with the AHAs back then, there will be varying provider configurations—then collected together as 'Districts'; now as various Trusts, with

even that name, a relic of the market reforms, probably not surviving in the longer term.

The HCB does not embrace the 'consensus management' *of* organisations associated with 1974, but it does mandate consensus (another paradoxical phrase) between the organisations required to collaborate, not least NHS organisations intended to collaborate with local government organisations in 'place-based management' (as indeed in 1974, although back then the word place had become jargon).

Despite this unspectacular reality, the Left sought to depict the 42 ICSs as deliberately floated-off from a hitherto unitary NHS, each of them beholden to, or ripe for takeover by, the private sector. This was, however, not the case. The reason for the suggestion of conspiracy was the fact that 'whole systems' contracts could be won by private companies, and two judicial reviews had upheld the legality of this. But subsequently the NHS Long Term Plan (Department of Health and Social Care, 2019) stated that there was an expectation that 'integrated care provider' contracts would be held by statutory organisations.

It had also been claimed, with some justification, that both NHS and EU law prohibited the exclusion a priori, as it were, of private alternatives. Since then, however, both Brexit and the repeal of the relevant bits of the relevant NHS law (i.e. the 2012 Act) proposed by the Health and Care Bill (HCB) of 2021 mean that the 42 ICSs will be expected to be public bodies.

These integrated care contracts were an outgrowth from the 'multispecialty community provider' (MCP) contracts which had sprouted locally under national tutelage and with development and consultancy input from 'insider' charities and think tanks, some of whose staff were the 'usual suspects' from the NHS reform consultancy 'industry' and punditry who had been close to the market reforms which they were now disowning while airbrushing from history their previous stance. So one can understand the Left being suspicious of those particular Greeks bearing gifts. But on this occasion they let their distaste for the messenger (and their suspicion of Simon Stevens as an 'NHS privatiser') cloud their judgement. With apologies to Marshall McLuhan, the medium was not the message.

For a flavour of the confusion around this issue, the debate on BBC Newsnight on 23 November 2021 to mark the HCB's Third Reading in the House of Commons was truly surreal. It involved: Dr. Andrew Murrison, a Conservative MP supporting *less* tendering and privatisation

(which had been enabled by the market reforms of both the Conservatives and New Labour); Alan Milburn, New Labour's pro-market Health Secretary from 1999 to 2003; and a left-wing Labour MP from the Socialist Campaign Group, Nadia Whittome. It illustrated a topsy-turvy world in which the Conservative was supporting his government's bill to promote collaboration, not competition, with no need for tenders leading to privatisation; the former Labour Health Secretary was lamenting the loss of 'his' NHS market with private involvement *de rigueur*; and the left-wing Labour MP was depicting the HCB as both privatisation and an end to a national NHS with uniform standards. (In fact the HCB gave the Health Secretary strong central powers.)

Milburn saw the bill as reversing a desirable devolution, showing that he had learned nothing—still believing that his Foundation Trust reforms and myriads of Primary Care Trusts had achieved devolved power and a better deal for patients, when in fact these reforms had forced back-door centralisation to prevent chaos and wasted billions without giving patients real choice. He now saw the future as *more* devolution, market and private involvement, to tackle the opportunities of genomics and data analytic innovations—a total non-sequitur. The ultimate irony was that it was Milburn's former health adviser, Simon Stevens, with whom he had worked on market reform, who had developed and championed the HCB. He had learned; his old boss had not. And, as pointed out above, Milburn failed to declare his interests in the private sector.

With Labour split between 'Blairite' outriders seeking more right-wing policy than the Tories and leftists who saw privatisation in the sort of reform for which they had cried out since 1990, it seemed the task facing their leader, Sir Keir Starmer, was a tricky one. The Labour leadership's opposition to the HCB was mostly tactical, but justified by the more grandiose claim (correct but irrelevant) that the HCB did not address the NHS staffing crisis. At the earlier committee and Second Reading stage, Labour had also opposed the HCB on the grounds that it did not tackle social care, but subsequently there was a social care initiative (see Chapter 10). Admittedly it did not tackle the issues on the equitable basis which Labour sought.

Nevertheless, it was highly likely that a future Labour government would find the *structures* created by the HCB congenial for its purposes. Where Labour's centrist leadership and left-wing backbenchers could find some common cause was in the belief that those structures could be used malignly by a ruthless Conservative government which wished to

feather-bed its cronies. But this had been, was and would be true of most or any structures. A lot of the suspicion of the HCB was of its potential abuse (e.g. contracts awarded de facto by crony Chairs of Integrated Care System Boards), and of the government sponsoring it (itself an irony, given the recent history of Conservative and New Labour market reforms), not of the inherent logic of the Bill's vision for the NHS.

For the reality was much more prosaic than the Left believed. ICSs would receive their money from the Department of Health via Regional offices, not wholly unlike the way AHAs got their cash from Regions. Between 1974 and 1996 there were fourteen Regional Health Authorities. But although these are long abolished, much of their work has been done by the back door by, first, Regional Offices, then the post-2006 larger Strategic Health Authorities, then (post-Lansley) Regional Teams.

The Bill prescribed mandatory members of the ICB comprising a Chair, a Chief Executive and 3 'ordinary members' appointed by NHS Trusts and FTs, local GPs and Local Authorities respectively. The ICS Design Framework also requires a Director of Finance, Director of Nursing and Medical Director as well as at least 2 independent Non-Executives. Directors of Public Health are also described as having an 'official role' in ICBs.

Coming Full Circle

The Health and Care Bill of 2021 meant that the NHS structure in England will have come almost full circle, despite new jargon to describe the latest policy, in the last 32 years, since the Thatcher government began in 1989 to implement the reforms announced in 1988 (Department of Health, 1989). Even as early as 2017, NHS England Chief Executive Simon Stevens was quoted as saying that Sustainability and Transformation Partnerships (one of the developments which, inter alia, prefigured the 2021 Bill) would end the purchaser–provider split, with the English NHS operating without such for the first time since 1990.

This ironical circularity 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 constructive evolution over 30 years (with the market reforms in that time somehow necessary and constructive) rather

than fatuous and expensive circularity, point to the fact the 'new' integration includes GPs and (to an extent) local government and social care. 'Insider' pundits also point to new ways of working which allegedly took various reforms to develop.

The 'old', pre-reform NHS, it is argued, was solidified in silos by the 'forces of conservatism', to use Tony Blair's phrase, which it took the catalyst of 'market reform' to unpick, whereas the new integration includes all key NHS actors. This is however misconceived. GPs will continue to be independent contractors who participate in (what will be statutory rather than voluntary) Integrated Care Systems as a result of exhortation or incentive. Such innovation has been possible throughout the history of the NHS.

Secondly, social care services (another key partner) are still outside the loop. No 'evolution' over the last thirty years has changed this; quite the reverse. (It was of course the Thatcher government which had peeled off the care of the elderly from the NHS.) Only by giving governance and control of the NHS to local government per se or by giving 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 aims of the HCB was to reverse the Health and Social Care Act of 2012 i.e. the Lansley reforms, and this seemed to include overturning the ethos of 'arms length' managerialism. Indeed the power grab by the government slipped into the Bill is wholly at odds with the philosophy first set out for the NHS by Roy Griffiths in his NHS Management Inquiry Report of October 1983.

Thirdly, and most importantly, most of the innovations geared to collaboration and 'integration' over the last few years, which have in the end been codified and rationalised into the HCB, 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 organisations (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 had been kicked off by Alain Enthoven's [1985] 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.

Commentators and advisers who have sought to shift ground seamlessly to give at least one-and-a-half cheers to each stage of reform, or at least to tag along with reform, waiting for the moment to advocate a new approach, risk giving the impression that each stage of reform is 'all part of the plan' (see for example Ham et al., 2011) and end up allowing a false narrative. It is of course a practical and personal calculation as to whether one can best operate from inside the tent or outside the tent. But Ham, for example, has quasi-defended market reforms (Ham, 1989, 2008; Ham et al., 2011) in terms which imply that they can be used for progressive purposes.

Moreover, presenting the 'vision' that Integrated Care Systems will be unlike any other organisation in the history of the NHS (Ham, 2021) is of a piece with the narrative that we have been on a journey, albeit a bumpy one, with 'integrated care' as the destination. Yet the reality is that, imperfect as the pre-1990 NHS organisations were, it would have been much more straightforward to develop 'integrated care' from those, as opposed to embarking on a tortuous twenty-five-year tour of the variants of the market. The narrative which paints ICSs as an evolution from previous reforms sanitises an *a*rational and often *ir*rational history.

There were those (apart from Conservatives or neo-liberals) who claimed that the purchaser/provider split was necessary to allow the need for care to be distinguished from existing provision. But a split was not *necessary*: what was required was a distinction between assessing need, developing (or continuing) services to meet that need and managing those services.

Others thought that a split would help discipline the hospital sector, which they thought was too large. But there was by no means an overprovision of hospital care in the UK. By comparison with Germany, France, Sweden or any well-funded country, that claim would seem risible. The pandemic showed, for example, that the UK's appalling death rate from Covid-19 could have been ameliorated at least to some extent—while still being appalling—if hospital capacity and associated intensive care capacity had matched Germany's. In blunt terms, informal rationing sacrificed thousands of old people who were not sacrificed in Germany.

Some progressive supporters of a split between purchaser and provider had more reason behind their cautious support, despite being anything but Conservative: they hoped it could lead to a more effective focus upon public health rather than business-as-usual. They sought to persuade the Labour Party between 1990 and 1992 not to oppose it. But with hindsight many of these (for example, the late Professor Walter Holland) consider that to have been a dashed hope (see Holland, 2010.) The years of the purchaser/provider split did not benefit public health. As the pandemic graphically illustrated, it was arguably the reverse.

Included in those who thought that the split might help to 'discipline' hospitals to the benefit of 'Cinderella services' were mental health advocates (such as the late Ray Rowden, a pioneering mental health nurse who became Director of the Institute of Health Services Management in 1993) and advocates for neglected community services. But what did happen, instead, was that incremental moves to bring hospital and community services into a more productive relationship were actually stymied, as separate provider Trusts (hospital Trusts; community Trusts; and mental health Trusts) 'gamed' against each other. The only way in which hospitals were 'disciplined' was in purchasers seeking to deny them money for care which they had no option but to provide (e.g. GP referrals which were not covered by purchaser/provider contracts).

When they formed a Coalition government in 2010, the Conservatives could have confounded expectations, built on their critique of New Labour's expensive market and abolished the purchaser/provider split. But their critique of New Labour focussed on the repeated re-disorganisations under Blair without linking those to the hunt for the market snark. Instead, they trashed their own critique of wasteful reorganisations by allowing Andrew Lansley, who had been Prime Minister David Cameron's boss back in his days at the Conservative Research Department, to 'marketise' even further.

But at last the Lansley mess had forced a rethink, albeit one led from within the service rather than government. Health Secretary Matt Hancock (presumably aware, like his predecessor Jeremy Hunt, that the Lansley reforms had been a car crash) accepted the conclusions of the NHS's 'bottom up' rethink, which less than two years later had become the Health and Care Bill, based on the preceding White Paper widely believed to have been masterminded by Simon Stevens. Hancock niftily added in extra powers for the Secretary of State, which was not what the NHS had wanted. Even this was however the antithesis of the Lansley approach.

One of the most politically striking and substantively astute sections of the White Paper leaked in February 2021, which led to the Health and Care Bill in August, made 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. This was politically striking because it came from a hard-Right government and astute because (for once) politicians had learned the right lesson from recent mistakes.

It was actually an advantage, if a great irony, that it was a Conservative government undertaking such a reintegration of the NHS. Had Labour done so—whether the party of Blair, Corbyn or Starmer—the Conservatives would have called it a return to the bad old days of bureaucratic planning, and some latter-day Lansley or Thatcher tribute-act would have sought their political monument in abolishing it. A government of the Right abolishing the market, however, was an example of what used to be called the 'Nixon to China' approach. Only a Republican President, Richard Nixon, who had built his career on anti-communism, could get away in the 1970s with meeting communist titan Mao Zedong; only the Conservatives can embed a sensible policy of which ideological right-wingers will be deeply suspicious.

A week is nevertheless a long time in politics, to quote Harold Wilson. The unusual circumstances facing the Conservative government in 2022 make 'embed' an optimistic term, I have to admit. The policy to 're-integrate' the NHS was associated with Health Secretary Matt Hancock. But he (unlike his boss Boris Johnson) resigned following a breach of Covid rules. Hancock's successor Sajid Javid, a health policy ingenu, had asked Johnson to pause the Health and Social Care Bill on being appointed, but had been overruled. Now, with Johnson weaker than ever, Javid trailed a return to the old ways—namely, hospitals independent of local area control following the 'Academy' model for schools. This was a first—a new NHS reform while a previous, contradictory, reform was not yet even on the statute book!

Sajid Javid's proposal for 'academy-style hospitals… to give well-run hospitals more freedom' (www.thetimes.co.uk, 2022) suggested he was ignorant of the recent history of NHS reform. Self-Governing Trusts were created after 1991 to do just this, as were (after 2003) Foundation Trusts, bolstered further by the Lansley reforms of 2012. Both types of the hospital still existed, but were strikingly irrelevant to the real problems facing the NHS. Javid's initiative was a 'zombie policy'—already

dead, but once again walking. Even worse: it was indeed incompatible with the Health and Care Bill of 2021, soon to become law, of which the official parliamentary sponsor was none other than the eponymous Sajid Javid. The Bill went clearly in the opposite direction: it was aimed at re-integrating area health services and indeed it made hospitals responsible to Integrated Care System Boards.

If Javid's new tangent was to carry weight, then NHS re-disorganisation, having been a pandemic which hit in repeated waves in the 1990s and 2000s, would have become endemic. Those seeking a more rationally organised and less wasteful NHS (such as the NHS Providers association, the NHS Confederation and indeed the present author) might after all have been premature in administering the market's last rites. Only time would tell.

Furthermore, Simon Stevens had retired as Chief Executive of NHS England in summer 2021, been ennobled as Lord Stevens of Birmingham and been replaced by career NHS manager Amanda Pritchard. Without in any way disparaging the latter, Stevens had had an independent power base and political inside-track resulting from his time in Downing Street and outside the NHS. Pritchard was a safe appointment given the alternatives, especially the arguably discredited Dido Harding (see Part III below). But she was less likely to 'make the weather'. Add to this that an important element of the Health and Care Bill was a political centralisation (discussed below.) If the Secretary of State wanted to undermine his own Act, there might be little to stop him!

At the time of writing, it is assumed nevertheless that the Health and Care Bill would become law and be implemented, with Javid's 'academy hospitals' somehow gerrymandered in order to be rendered compatible. After all, the self-governing Trust and the Foundation Trust had quickly been neutered into a shadow of their former pretensions. But nothing was certain. Such are the hazards of writing about events whose consequences protrude into the present and future. Prime Minister Boris Johnson was on the ropes. He had destroyed his reputation with most of the public and many of his own MPs through his and his associates' failure to obey the Covid rules which he had reluctantly devised. Added to a tissue of corruption allegations and a casual relationship with standards in public life, he had become a very weak leader of his party. So Sajid Javid, supported by backbenchers and others who objected to a 'socialist' reform of the NHS, might be able to resist.

For now, assuming that were not the case, the HCB was a step in the right direction. Routine tendering for services, both expensive and demoralising, was to be abolished. A rigid tariff for services was to be made more flexible, although the devil will be in the detail. The fragmentation of agencies heading up the NHS at the national level was to be ended. And most importantly of all, local NHS authorities were to bring together hospitals, other providers, commissioners (planners) and GPs. Some regretted the end to a quasi-'autonomous' national NHS board. And, to be sure, if direct political control is of the malign variety, policy suffers. But in a tax-funded, politicised service, pretending political control does not exist may be a recipe for behind-the-scenes skulduggery rather than honest political ownership.

Former Conservative Health Secretary Jeremy Hunt, reincarnated as Chair of the House of Commons Select Committee on Health, welcomed the approach taken in the new White Paper. Former Prime Minister Theresa May (2018) and the now-merged NHS England and NHS Improvement (2019) had prefigured it with their own stated intentions. But would Labour approve of the Bill?

Had not Labour been calling for just this? Labour in the form of previous Health Secretary Andy Burnham had claimed that 'Accountable Care Organisations' (an Obama initiative in the USA and allegedly part of the inspiration for the Health and Care Bill's new Integrated Care Systems), were *its* policy, not that of the Conservatives.

Labour voted against the second reading of the Bill in September 2021. This was however on tactical grounds: the objections stated by Jonathan Ashworth, then Shadow Health Secretary, were grandiose e.g. that social care was not dealt with in the bill (true but irrelevant.) Ashworth did, moreover, welcome the end of Lansley's 'Section 75' tendering i.e. the compulsory market. Wes Streeting, Ashworth's successor, 'reluctantly' supported the Bill. It would not have been sensible to do otherwise.

We should note that Amendment 25 to the HCB in the Committee stage prior to its Third Reading on 23 November 2021 prohibited from membership of an ICS board anyone whose role in the private sector could compromise the independence of the NHS (UK Parliament, 2021). This was not of course enough for those who wished for a total ban (see next chapter). It was to be up to the Chair of the Board how this would be handled. So any devils would be in the detail, or rather in how the HCB was *used* by future government guidance.

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CHAPTER 7

Left Behind: Opposition to the New Approach

Suspicion—My Enemy's Policy Must Be Wrong

The HCB was opposed by the Left. By the Left, I mean a variety of groups with various stances, including diehard supporters of Jeremy Corbyn, former Leader of the Labour Party, some of whom remained in the party and some of whom had left; campaigning groups such as Public Matters which identified most 'public sector reform' as neo-liberalism; and sincere socialist-minded clinicians and others in groups such as Keep Our NHS Public (following on from the NHS Support Federation). One may also note the National Health Action Party (which had grown out of the one-off electoral success of Dr. Richard Taylor), not necessarily Left per se.

And the HCB was also opposed by high-quality academics such as Allyson Pollock who had produced valuable research and criticism of the rightly discredited Private Finance Initiative—which was vindicated to the extent that the Conservative government in 2021 used New Labour's support of the PFI (originally a Conservative policy before 1997) to attempt to discredit Labour's criticism of Conservative cosiness with the private sector! Pollock's work on the PFI had been traduced by those who ought to have known better, including Alan Milburn, but she was right, as all parties came to recognise too late.

Non-partisan but anti-privatisation critics of the HCB included the Centre for Health and the Public Interest, which has rightly warned

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of the dangerous uses which might be made of the HCB by a shameless government such as Boris Johnson's. Following on from the various procurement scandals during the Covid pandemic, it is feared that the end of market-based procurement and tendering might simply lead to money and contracts being awarded to corporations, business interests and individuals close to the Conservatives and individual Ministers.

The common thread to many of these groups was that there was a remorseless logic to all the NHS reforms since 1990. The thesis is that the introduction of markets into the NHS was geared to privatisation, usually inspired by 'the' (*sic*) American model, *and that the 2021 HCB represents the apotheosis of this process (and not its reversal*). In other words, the HCB represents continuity with and extension of, not correction of, the previous reforms.

The rump of the Corbynite left within and without the Labour Party, for example, claimed this with certainty, sometimes serene and sometimes seething. It is of course a tempting argument to those on the hard Left for whom all battles are struggles for the ideological soul; whose ability to cry 'betrayal' or 'privatisation' is perennial.

But for those who sincerely believed it even when seeking to understand the policy, this view stemmed from a clear failure to distinguish between the new structure proposed and its possible (illegitimate) use by devious politicians. Being suspicious of Conservatives bearing gifts is certainly understandable. But the hard Left critique of the new policy is misconceived. It is understandable, because, up until now, the very phrase 'NHS reform' savoured markets and even privatisation. But it is confused because, while previous reforms have been about developing purchaser/provider splits and contracting this reform is the opposite.

Of course, the charge of conspiracy is more convincing, even if wrong, when the government introducing the HCB in 2021 was that of Boris Johnson, a man who had presided over the UK's dystopian Covid-19 nightmare and whose arguably cavalier attitude to running public services included his government seemingly being guilty of cronyism. A Conservative peer was chosen to run Test and Trace during Covid-19's first year; contracts for equipment during the pandemic went to Conservative supporters and there was an unsuccessful attempt to help to exonerate former Cabinet Minister Owen Paterson from the charge of breaking accepted standards in public life for an MP.

Nor does history help. For example, Simon Stevens, in a previous incarnation, seemed to epitomise market reform. His journey from having

advised Frank Dobson, 'Old Labour' Health Secretary from 1997 to 1999, through advising Alan Milburn, then Blair, then heading up a division of US-based UnitedHealth before returning to head up NHS England, could easily be presented as a Rightwards journey which makes his old boss Tony Blair's (2010) political autobiography tame by comparison. That would be inaccurate but plausible.

It was not only the author of the new approach who raised suspicion but also some of those who now followed in his slipstream. Take for example the former King's Fund Chief Executive, Professor Sir Chris Ham. A problem for HCB defenders is that Ham, a leading proselytiser for the developments leading up to the HCB which heralded 'integrated care', had also been a defender, albeit a cautious one, of significant aspects of previous reforms from 1989 onwards (see Chapter 6 above). This point should be qualified, in fairness: the King's Fund had in due course criticised the Lansley Act. But then this was an egregious monster disowned by nearly everyone. All the same, to be charitable, perhaps Ham's approach over the decades had been to hug each reform in the way that outgoing US President Bill Clinton had advised Tony Blair in 2000 to 'hug' his successor, George W. Bush. In other words, it was an attempt at constructive pragmatism.

Such an approach meant 'critically accepting', and then suggesting alleged improvements to, each stage of reform. This approach may seem to be a pragmatic one, but it has its limitations. Ham was Director of the Department of Health Strategy Unit, at the time when a serious fragmentation of the NHS, the antithesis of 'integration', was occurring via Alan Milburn's market reforms. Even if this is no more than 'coincidence', such a history does not help those who are suspicious of the HCB to see it for what it is—a *reversal* of the market policy. Interestingly, the Labour Left's *bete noire*, Alan Milburn, sees it like that, for sure, and deplores the fact: given his enthusiasm for the private sector and the NHS using tendering and contracting to involve it, he deprecates the HCB, as discussed in Chapter 6.

Decades of market reform were *not* necessary to develop integrated care: they were not necessary for theory or in Scotland (to use a zeugma).This was quite reasonably pointed out by Scottish National Party MP, Dr. Philippa Whitford in the bill's Second Reading debate (UK Parliament, 2021). The HCB has rightly been seen by those outside England who defend a public NHS as a step in the right direction but quite timid: this reflects its origin amidst the legacy of England's market

reforms. To that extent, it suffers from 'path dependency', in the language of political science.

One worry expressed about the HCB by both critical defenders and opponents is its 'centralism'. NHS Confederation (2021) Chair Matthew Taylor raises two cheers for the HCB, one might say, but has reservations about allegedly excessive powers given to the Secretary of State. I do not entirely share that worry. The anxiety about centralism, apart from the fact that it is a 'boo word', stems from two sources: firstly, that local closures of services may be overridden for political reasons (or, inversely, that local decisions to keep services open may be overridden); and secondly, that local energy and initiative geared towards genuine collaboration will be vitiated. To my way of thinking, making centralism (which is close to inevitable in national service) overt rather than covert has advantages.

I do however accept that centralism in the wrong hands can be insidious. And indeed an example of the wrong type of central political control occurred even before the Act was passed, when Health Secretary Sajid Javid seemingly overruled NHS England CEO Amanda Pritchard in January 2022 in allocating money to private providers—not in return for an agreed quantum of services but to retain their cooperation if a resurgence of the Omikron variant of Covid affected the NHS more than anticipated.

Yet, separately, it is ironic that the hard Left depicts a central role for the Secretary of State for Health as a Tory plot: it is little more than ten years ago that the *removal* of the Secretary of State's responsibility for the provision of health care throughout the NHS was being depicted as a Tory plot.

The HCB offers a reasonable place for a future Labour government to start in its task of entrenching and strengthening a *public* NHS. This is not to deny that there were and always will be dangers involved in 'integrated care' in the hands of Conservative governments, especially those which award cosy contracts to private companies. On the one hand, ending tendering is a good way of closing down a wasteful market. On the other hand, in the wrong hands, it could mean a sleazy way of awarding contracts to cronies without a transparent process and proper scrutiny.

Furthermore, the 'commissioning' arm within integrated care systems (with or without capital letters) can in theory be privatised, if precedents under both New Labour pre-2010 and post-2010 Coalition and Conservative governments are built upon. New Labour's grandiose failure, World Class Commissioning, involved large expenses on consultancy and

outsourced advice to create which were largely tick-lists for commissioning processes which NHS managers should have had as part of their basic skill-set. UnitedHealth and others have been engaged to 'run' commissioning pilots which could just as well have been done in-house at much less expense.

All of this helped feed the suspicion that what was being sold as 'integration' was (also) also privatisation and/or Americanisation. But it is important to separate the *analytics* of reintegration from the *politics* of its implementation. Those who find it difficult to separate the analytics of the 'new integration' from the politics in effect depict what I call a circular process as a spiral: they argue that the NHS has not abolished the market and rendered thirty years of reform a digression, but has spiralled off in a different direction, in the process weakening it further as a well-funded and public institution.

But at the end of the day one may ask a simple question: will it be possible for a future government that is unequivocally to a well-funded, public NHS with national standards in services and provision to use the *institutions and logic* of the Health and Care Bill (HCB). The answer is yes.

Admittedly those charged with providing strategic advice to the Conservative administrations since 2015 have been foolish in giving hostages to fortune. At the very least they have used language which suggests a fascination with the mechanics of the US Health Maintenance Organisations and their more recent sibling, the Accountable Care Organization.

And they have also sometimes gone further. One particularly ill-advised paper (The Strategy Unit, 2018) from an organisation hosted by one of the NHS's 'commissioning support units' (an example of the sort of cumbersome organisation necessary to hold the NHS together in the wake of the Lansley reforms' centrifugal forces) airily talked of possible options for distributing any 'surplus' achieved when a provider met its targets within a capitated budget with money left over. This raised the possibility of a private provider which had already received income (including profit) from its contract with the NHS receiving a second dollop of profit—a direct leakage from the NHS of money which could have been used on services. While the paper also mentioned the risks as well as the rewards of such an approach, the genie was out of the bottle in the eyes of those suspicious of ICSs.

But the reality is that, whatever the loose talk and even genuine inspiration from HMOs and ACOs (and there has been plenty), the English context is wholly different. US HMOs function by attracting customers, whether individual, corporate or governmental. The US government is but one payer in a very mixed (non-) system. In England, a tax-funded NHS will remain, and the aspects of the HMO which appealed to many of the policy wonks who brought it to the attention of Ministers are internal integration of 'commissioning' and provision, the latter also comprising integration across different services.

That is to say, it is the comprehensive HMO such as Kaiser which is the inspiration, or should be—not the disreputable cost-cutting, corner-cutting for-profit HMO which brought what was originally (ironically) a socialist alternative to mainstream US medicine into disrepute. And even then, it is the mechanics of the HMO, not its political-economic context in the US market, which is relevant.

Ironically most English advisers and Ministers are unaware of the complexity of the HMO debate, and the diversity of the HMO landscape, in the USA. They are rashly dazzled by sexy-sounding 'initiatives' which are hostages to fortune and which allow their diehard political enemies to cry foul, with enhanced plausibility.

In the USA, HMOs compete with each other and other forms of provider. In England, the idea that there would be enough capacity for competing 'integrated organisations'—or even for competition among the significant individual service or provider components of these organisations—is risible. There is a shortage of staff in clinical (indeed all) cadres, not a surplus. There could of course be competition involving (and between) private companies to take over providers. But it is the *current* system, which mandates that, through compulsory tendering ('Section 75' of the Lansley statutes). Compulsory tendering is being abolished. We have seen experiments in privatisation of management repeatedly over the years—it would not be as a consequence of the HCB. And in general, they have not ended well.

But neither does the idea of competing public integrated systems make sense: it is a solution in search of a problem, an answer in search of a question. In essence, competing public 'clinically integrated' systems would be the internal market all over again, in new clothes. And with the NHS as not only 'preferred provider' nationally and locally but with NHS ICSs which do not have to submit themselves to compulsory tender, the English NHS can be free not only from cumbersome pro-private

markets than it has been in the past but also from the stage-managed public-sector internal competition which is expensive and disruptive. Ham (2008), for example, having seemingly been attracted to competing integrated providers, had in any case moved on from his 2008 stance by the time that ICSs became the new orthodoxy, dropping the market component and concentrating on the integration per se (see for example NHS Confederation, 2021, for the flavour of his views).

* * *

The HCB was far from perfect. This was the result of it being a rationalisation of the piecemeal initiatives (from 2015 to 2021) upon which it was built. These in turn had been rather timid attempts to use the dysfunctional market architecture prevailing in the NHS prior to the HCB. Since 1990, a series of reforms had applied a blunderbuss to reform the NHS when a rapier was required; a sledgehammer to crack a nut. The resulting architecture was subverted cautiously and gradually, from 2015—overseen by a Conservative government which itself was less than sure of its feet and nervous of its right-wing backbenchers. So that sometimes meant using market language, even as the NHS market *qua* contracting and strict purchaser/provider splits were being reined in. The language was tactical, to 'head off Tory opposition at the pass'. So it is understandable that some who were anything but Tories took some of this at face value, especially the references to American health policy.

The US Connection Unpicked

'Americanisation' is a loaded charge on the left and beyond when it comes to the NHS. Mention of either the 'ACO' or the 'HMO' is like raising a red rag to a bull. Yet Accountable Care Organizations were a timid attempt by the Obama administration to reconcile cost-control in a profligate but inequitable US market with more 'integrated' and comprehensive care than merely a set of fee-for-service episodes in an acute hospital. The aim is the same as with HMOs—the clue is in the name, health *maintenance*—which is to keep people healthy rather than patch them up. Now, this may be done on the cheap or not done properly at all. But it is a strange thing to see left-wing hysteria against the HCB on the grounds that it is seeking to give incentives to keep people healthy rather than send them to hospital.

In 2002, an article in the *British Medical Journal* (Feachem et al., 2002) had compared the Health Maintenance Organisation (HMO), Kaiser Permanente, favourably with the NHS in terms of various factors—the ratio of senior hospital doctors to patients and cost-effectiveness in particular. Although it was a serious academic comparison, it can be critiqued in various ways. But as might be expected, its favourable reception in the UK Department of Health depended upon its timing: this was just as New Labour was embarking on its own market reforms. NHS Chief Executive and Department of Health Permanent Secretary (the roles were combined at that time) Nigel Crisp sent one of his Regional deputies to learn from Kaiser. Subsequently, Minister of State at the Department John Hutton oversaw some cooperation with Kaiser officials in some 'pilot sites' in the NHS.

The fact that the 2001 and 2002 reforms in England were sending the NHS in a diametrically *opposed* direction to Kaiser's 'integrated care' (which was based on both 'integrated provision' and an integration of 'purchaser' and provider in the same organisation) was neither here nor there. The *language* of the HMO was used in the pilot sites. It meant little in substantive terms, in an English world of a purchaser/provider split deepened by the creation of wholly inexperienced Primary Care Trusts, on the one hand, as purchasers and (from 2003 onwards), on the other hand, as providers, a confusing landscape of 'autonomous' Foundation Trusts (hospitals, mental health providers and a variety of community services) and Self-Governing Trusts (inherited from the original internal market but which Milburn had decided were not self-governing enough).

Later on, the US corporation, UnitedHealth, was engaged to advise the floundering Primary Care Trusts (PCTs) on how to commission better. This was another expensive diversion. The fundamental problem was not a lack of commissioning *nous* or skills (although the poor quality of many commissioners was legion), but firstly, that small-scale 'commissioning' was dysfunctional and, secondly, that commissioning per se was incompatible with the central diktat on targets and priorities which also characterised 'control freak' New Labour. After Alan Milburn lost his battle with Chancellor Gordon Brown over health reform (although winning a few skirmishes) and left the scene, John Reid took over as Health Secretary and minded the shop for a couple of years before Patricia Hewitt tinkered around with the dysfunctional system. Hewitt did at least merge PCTSs into a slightly more tenable size. Then Brown became

Prime Minister in 2007, replaced Hewitt with Alan Johnson and back-peddled on the market philosophy, if not on the details of the policy per se.

Under Brown, Alan Johnson and then Andy Burnham sought to downplay market language and indeed substance to an extent, with Burnham distancing himself from the muddled market enthusiasms of yore by designating the NHS as 'preferred provider'. Hewitt's erstwhile deputy, Minister of State for Health Lord (Norman) Warner and Blair adviser (2006–2007) Paul Corrigan threw a few brickbats in Burnham's direction, sensing (correctly) that the high noon of the market was over and that their approach was dead.

Some on the fundamentalist Left see this as Burnham using market language, showing that there was a linear move over time in the market direction. This is however mistaken: what Burnham was seeking to do was row *back* from the Milburn–Warner market proselytisation. 'Preferred provider' is a market term, yes; but it savours of mature industrial markets, not banana markets. And Burnham was trying to say, 'look - the *NHS* should be the provider unless there is a reason for it not to be'.

Some years later, when Shadow Health Secretary to Jeremy Hunt, Burnham responded to the latter's espousal of another American idea, Accountable Care Organizations (this time from the Obama playbook), by saying in the House of Commons that 'that was *our* policy'. Again, this was misunderstood by the absolutist Left as showing that he was a sell-out to Americanisation. He was in fact saying that Labour favoured a move to integration rather than stark purchaser/provider separation. What made a good debating point in parliament was of course a hostage to a fortune on Burnham's part in terms of his credibility within a soon-to-be-Corbyn-led Labour Party but he was doing no more than pragmatically recognising where England's NHS was after 25 years of 'the market' (unlike in Scotland, for example, or to a lesser extent Wales)—as well as seeking to deny Hunt and the Tories sole ownership of the 'reintegration' agenda in the slipstream of the Lansley debacle.

'Americanisation' in the NHS does not *necessarily* mean either marketisation or privatisation: it depends on what one is referring to. The American experiments which the NHS has—superficially—engaged with are themselves reactions against traditional models of fee-for-service medicine. One such, the Veterans Health Administration, is as public as the NHS, if not more so. Others, such as Kaiser, are not studied for their

operation in a private market where they have to attract subscribers (citizens/consumers), but for their management characteristics, for better or for worse. The USA at the 'macro' level has an inequitable healthcare system, or rather, as long-standing CBS news anchor Walter Cronkite once put it, an '*un*healthy *non*-care *non*-system'. But some of the specific institutions to be found at the 'micro' level in that non-system may be of interest.

'Corporate Rationalisation' Need Not Be Private

There is one area where basic NHS principles have been eroded over the years under all governments, however. The NHS was a great act of rationalisation (as well as a nationalisation) in 1948. The mobilisation of the state's authority to provide health services was a response to their unevenness and poor organisation as well as a socialist endeavour. That agenda remained unfinished for decades and still is arguably so today.

In the USA, the forces of rationalisation, to the extent they exist, came about from the 1970s onwards, picking up speed in the 1980s and beyond. The major difference with the UK is that these forces were the forces of private, for-profit corporatisation. Paul Starr (1983) referred to this as the 'social transformation of American medicine', Robert Alford (1976) having written previously of 'the corporate rationalizers' challenging the dominant elite of individualistic, fee-for-service medicine.

In terms of both its capacity and the prospects for completing the job of rationalisation, the problem for the NHS today is that it has been relatively starved of public capital since the 1970s since the economic crisis of 1976. This economic origin of scarce capital has led, even in times of plenty, to what almost amounts to a *cultural* assumption that both private capital and the use of private facilities to provide NHS services are necessary (and desirable). It is cultural in the sense that it is accepted unthinkingly. Even Frank Dobson, anti-privatiser, saw the PFI as simply taking out a mortgage, and was in favour of it. He was wrong in that. The Labour government initiated the public–private 'concordat' in 2000, a grandiose name for a well-meaning but over-centralist and inefficient policy, irrespective of one's ideological bent.

The pandemic showed us—too late—that running down public provision in a complacent manner will, in bad times, lead to blowback, as the Americans call it. An impoverished public health capacity meant resorting

to a privately run new Test and Trace system which failed, and where private contractors were richly rewarded through meeting 'targets' which bore no relation to meaningful outcomes. The local government's health protection capacity had long since been run down. At the national level, Public Health England was a pared-down, politically quiescent quango.

For the NHS as a whole, public capital is generally more economical and efficient and acquired more cheaply. Often archaic Treasury rules put its procurement at a disadvantage. The PFI has shown us on a staggering scale that there is a terrible cost to short-termism. And huge money have been spent over the years, decades, on buying services for the NHS from the private sector which could have been spent on investing in the public sector.

This is not to deny that there are occasions, and they are *occasions,* when private sector collaboration may be useful. But to continue and complete the mission of NHS rationalisation—from securing adequate and evenly distributed GP services throughout London, to boosting community services, to new hospitals and in-patient mental health facilities nationwide—through hiring private corporations is poor economics and a hostage to fortune.

More Detailed Worries

There were however other worries about the HCB—more nuanced, but more real. Integrated care will fail if it is about starving the hospital to feed other, under-nourished components of the system. ICSs grew out of the Sustainability and Transformation Partnerships (STPs) which were overtly a reaction to the 'economic winter' facing the NHS post-2009/2010 (post-financial crisis) and to this day. The debt incurred by the Covid pandemic and the Johnson government's disastrous 'lose-lose' reaction to it (losing on both health and the economy through reckless short-sightedness) means that the medium-term holds no hope of generous budgets from any government of any political stamp, despite some headline budget increases for the NHS announced towards the end of 2021.

The conundrum is as follows. Keeping people out of the hospital to a significant extent requires both significant expenditures on community services and societal responsibility for avoiding ill-health through lifestyle. More than this: in the short term it requires continued increasing hospital expenditure *as well*, as the lead-time for success is long. It is rather like

an integrated public transport strategy. It will only work if the public investment is genuinely eye-watering and well-planned.

None of the pre-conditions for reduced hospital use is likely. In the past, governments have 'talked the talk' about shifting the balance away from hospital care but it has been hot air. It still is. Therefore ICSs, even after years, will not produce some brave new world. They will face the same problem a cash-limited NHS has always faced—mending the boat while sailing in it, which requires in the short and medium terms 'double spending' i.e. developing new services while *also* funding the hospital care until the brave new world comes into being.

There will be no legitimate 'surpluses' for private providers which allows them to meet their care obligations conscientiously (the spirit, not just the letter) and still have money left over. This will only happen if the NHS writes tick-box contracts which allow them to deny care or provide less-than-adequate capacity or quality, yet meet their targets.

More likely is the drying up of the private provider market for services within ICSs, as the private sector finds that meeting (meaningful) targets within the allocated cost-envelope is impossible—not for the first time in the NHS's history.

Another worry about privatisation concerned the possibility of GP services being privatised through a corporatised contract, as existed with Centene in London and was expanded in late 2021 even as the HCB was progressing through parliament. It should be noted however that this was not a development enabled by the HCB—it was occurring already. In other words, if the government of the day wanted to implement such privatisation, it would do so. Critics argued that GPs should remain NHS employees (although most were in fact private contractors!): what they meant was that the GP service should not be corporatised through encroachment by for-profit companies. Admittedly the excuse for corporatisation was sometimes that there was a shortage in a particular area which 'required' a different approach. The HCB was neutral on this. Those who feared the 'Centenisation' of the NHS GP service (US company Centene had bought a significant number of London's GP practices) feared the politics of privatisation in general (pre-HCB politics, to boot), and its implementation by NHS regional managers—not the specifics of the HCB.

What diehard opponents of the HBC on the Left (and beyond) feared was the NHS becoming a rump—a service for the poor that becomes a poor service. Organisations such as ICSs would then become a *mechanism*

for instituting the (increased) rationing which brought about this sorry state of affairs. This was of course a danger. But it always has been, in the context of governments not trusting the NHS.

It was claimed to be happening with the Griffiths changes of 1983; with the NHS and Community Care Act of 1990; with GP Fund-Holding; with New Labour's reforms; and especially with the Lansley Act of 2012. It was ironical that it was now claimed to be happening with the reversal of much of the above. The truth is that the new English NHS will be neither a harbinger of doom nor a guarantee of its avoidance. It will, at best, do something much more modest—reduce waste in governance, if properly implemented, through abolishing purchaser/provider markets and obsessive tendering for contracts; make political control (always omni-present) more overt and less hypocritical; and allow a unified 'health authority' (the ICS) to be clearly responsible for services, without buck-passing from 'commissioners' (purchasers) to providers and back. If these are cut to the bone or rationed, which they may well be, we know whom to lobby or blame.

One legitimate source of worry is that the GP service could change qualitatively, for the worse, if GPs do not have a right to treat their patients in primary care and/or of 'free referral' to secondary and other services, without regard to cost. Having GPs free to express the needs of their patients as they see them in this way is an important safety valve for the NHS. Opponents of the new approach have some reason to fear that if the GP service loses its relative autonomy and (judged in the round) public service ethos, then patients will suffer: all of health care will be a business concerned with the bottom line.

But of course, neither is this new nor easily addressed. In 1983, the Thatcher government was investigating cash-limiting the GP service (the rest of the NHS having of course been cash-limited since 1948) through the Binder Hamlyn management consultancy. Later, a 'limited list' of drugs that GPs were allowed to prescribe was implemented—temporarily. GP practices have been de facto cash-limited within the overall NHS budget since what were separate Family Practitioner Committees became, firstly, Family Health Services Authorities after 199, subsequently becoming part of the Health Authority, before (after 1997) becoming part of the responsibility of first Primary Care Groups or 'voluntary' Primary Care Trusts, then (after 2001) universal Primary Care Trusts, then (confirmed after Lansley's Act was passed finally in 2012) Clinical Commissioning Groups.

Indeed since the Lansley Act in 2012, there has been a direct conflict of interest between the GP's right of 'free referral' and the financial interest of the CCG. Before CCGs, GPs could at least refer freely (with the temporary exception of GP Fund-Holders (1991–1998) who had to manage within their specially allocated budgets. PCTs were not GP-controlled, but were traditional health authorities in the sense that they were controlled by NHS managers, although advised by a GP-led 'Professional Executive Committee'. But CCGs, cash-limited for both their own services and the services for which they contract, are GP-controlled.

So an ICS which allocates money to GPs on the basis of (obviously cash-limited) capitation is not new. In fact my recommendation would be that GPs do *not* control budgets themselves, whether within ICSs or in any other system. They can then be patients' advocates whatever the overall cash envelope, without it being a direct conflict of interest withholding the budget themselves, let alone profiting from any surplus within it.

A Different Objection to the HCB: The 'Commissioning' Lobby

I disagree with some of the more constructive, pro-NHS critics of the Health Care Bill—not conspiratorial or diehard leftists—who argue that it is unwelcome because it removes at a stroke the role which GPs have accumulated over time in 'commissioning'. Yet I have always considered it a mistake to see this as 'progressive' and pro-patient: this very role compromises the GP's role as a patient advocate. Let me explain.

The Thatcher–Clarke internal market created GP Fund-holding. There were also 'Total Purchasing' experiments in the late 1990s which gave all GPs, whether fund-holding or not, purchasing budgets. New Labour created PCTs and Lansley CCGs. Over this long timeframe of reform, GPs had to take responsibility firstly for rationing or at least prioritising care in secondary and community and then gradually (through the PCT or directly themselves in CCGs) in their practice-delivered primary services. Some—a minority—were enthusiastic; many went along as a political necessity; the majority were opposed, with varying degrees of negativity ranging from fatalism to outright hostility.

This is not to deny that rationing is here to stay. It is to say that the HCB and what it represents is not creating a new monster: it is recognising a long-standing spectre.

The constructive, pro-NHS critics of the HCB bemoan the passing of GP commissioning' on the grounds that the GP is closest to the patient (Andrew Lansley's point too in creating CCGs) although of course GPs will be represented on the ICS Boards. But in reality, GP commissioning was a cumbersome and expensive exercise that could not get around the reality that *real* planning, call it strategic commissioning if you must, had to take place at a higher level. The GP role was not about creating or changing the configuration of services overall, but making suggestions as to such while having a more direct influence upon the more 'micro' matters.

Fund-holding was too small. Total Purchasing, which enlarged it and extended it, was the Health Authority with different staff (and why should GPs as opposed to other clinicians have the seminal role? Or, as the late Alan Maynard put it, how come GPs were the villains in the 1980s and the heroes in the 1990s? The truth is they are neither). PCTs had to merge in yet another disruptive reorganisation before the ink was dry on their creation to make commissioning even semi-viable. CCGs likewise.

So for Alderwick et al. (2021) to decry the reorganisation inherent in the HCB is illogical. They rightly point out that past reorganisations have generally disappointed, and that (despite, incidentally, the last two these authors having been fans of GP commissioning), commissioning, strategic or otherwise, generally has not worked. So their conclusion is that another legislatively mandated reorganisation should be avoided, or at least carefully reconsidered. But if the aim of the latter is to undo the harm done by previous reorganisations (which have not just, in my view, failed to help much, but which have *harmed*), it is illogical to assume that a rationalising reform will be more of the same. Of course integration per se as a structural change may disappoint. They are right in that: it may not be sufficient. But it may be necessary.

Mays and Dixon, Alderwick's co-authors, have been, with reservations along the way, supporters of local commissioning, although their plea to avoid the upheaval of reform inherent in the HCB does include, to be fair, the acknowledgement that local commissioning has disappointed in practice (Alderwick et al., 2021). My view is that local commissioning has not worked, not (only) because it has not been properly implemented but because it is the wrong approach per se. It is ironic that those who are now sceptical of reorganisation to reverse previous reorganisations, on the grounds that reorganisation always disappoints, were much less critical of the previous reorganisations which brought the NHS into chaos.

Alderwick et al. try to have it both ways: they claimed that the proposals which led to the HCB would maintain commissioning, and so why, they imply, is it necessary to legislate? The word may be used, for sure, in the cliched and pretty ambiguous form of the 'strategic commissioning', to be conducted by ICSs. But this would actually be more like area planning. It would avoid the flaws in 'local commissioning' which had been associated with the fragmentation of an over-decentralised and over-marketised NHS.

Since the 1990s, the fans of small-scale commissioning generally had given the market reforms two cautious cheers on the grounds that they enabled it. They were positive about the purchaser/provider split primarily because it enabled a central role for GPs in 'commissioning'. During the era of the Conservative internal market in the 1990s, Jennifer Dixon was both an enthusiast for GP Fund-Holding and was close to the internal market, at one time being adviser to Alan Langlands, the NHS Chief Executive from 1994 to 2000, who was responsible for implementing the internal market through the framework of 'local freedoms, national responsibilities' (NHS Executive, 1994).

The argument that more structural change was 'against the evidence' is misleading. Such evidence (that new initiatives did not easily produce benefits) was limited to evaluation of *particular commissioning* initiatives, including ironically some of the structural changes which the enthusiasts for local commissioning, who now deprecated its abandonment, had supported. There was no evidence to suggest that GP commissioning in the context of a purchaser/provider split was anything other than uneconomical, inefficient and possibly ineffective (in terms of securing hospital services) when compared to higher-level planning.

Thus the 'local commissioning' constituency was sceptical of 'structural change' when it was geared to abolishing purchaser/provider markets, despite having been sanguine about the much more disruptive structural change which had created and extended these markets in the first place. Labour's new Health Secretary Frank Dobson in 1997, pledged to 'abolish the internal market' on grounds *inter alia* of its high cost, was for this reason irritated by Mays' intervention when the latter argued on BBC Radio 4 that the savings would be trivial.

Again to be fair, Mays' research—the high quality of which was not in doubt—did not suggest system-wide benefit from local commissioning, as opposed to more localised benefits in the realm of certain community

services, and not including acute care. An example was his work as a principal evaluator of the 'Total Purchasing Pilots' (Malbon et al., 1998), a potential new direction for the internal market introduced towards the end of the Conservative government's tenure in the 1990s, and arguably a forerunner of Primary Care Trusts, via Primary Care Groups. Later, he was the official evaluator, with a different Dixon and Jones, of New Labour's market reforms, coming to the conclusion that they had not done harm, but that their cost was unknown (Mays et al., 2011). Much of this research was both good and useful but the 'punchline' was paradoxically both superficially underwhelming and yet striking. Nothing better than the absence of harm at unknown (but clearly high) cost? This was hardly a justification for the upheaval, cost and diversion from more important challenges for the NHS.

Such evaluations moreover were hardly the basis for an argument against a new White Paper, and subsequent Health and Care Bill, which built on work already underway in the English NHS and which therefore was 'with the grain' rather than against it. This is not to be insouciant about the risks with any structural change; it is to counsel against double standards.

The Balance Sheet—Unpicking the Threads of Confusion

Some on the fundamentalist Left claim that the Health Maintenance Organisation and the Accountable Care Organization are insidious American institutions being invoked and used as part of a privatisation agenda advanced by the Health and Care Bill. This is wrong. In the USA, both were devised, decades apart, primarily in response to the problems of the US healthcare system to the fragmented US healthcare market, although the HMO idea was certainly corrupted in the hands of both the private for-profit sector and those who used it to cut public healthcare costs (primarily in Medicaid).

The irony is that the English NHS has, over the last few decades, gone down the road of market fragmentation—in provision; in purchasing ('commissioning') and in the relation between the two. This has of course occurred in England in a very different context of a publicly financed NHS. Nevertheless, as in the USA, there are now moves to integrate, or rather to reintegrate, of which the Health and Care Bill is the apotheosis.

These moves have borrowed the language of American initiatives—as with ACOs (Charles, 2018).

For those Leftists who think it is only Blairite 'neo-liberals' (as they call them) and the Right in politics who have talked the language of the HMO, consider the following. In 1997, Frank Dobson, anything but a Blairite, was appointed Health Secretary and inherited GP Fund-Holding (GPFH), the jewel in the crown of the outgoing Conservative government's internal market. His NHS White Paper, Modern and Dependable, abolished GPFH and absorbed it into new Primary Care Groups involving *all* GPs. An analogy was drawn with the HMO (not necessarily accurately, but that is not the point). Yet this was an *integration:* the aim was overtly stated as 'reintegration without reorganisation'. Simply flinging around the term 'HMO' as a term of abuse is either uninformed or disingenuous.

A second confusion concerns the relationship between the 'purchaser/provider split' and privatisation. The claim of the Left from 1990 to 2012, in opposing the market reforms of Thatcher, Blair and Lansley, was that the purchaser/provider split aided privatisation. Yet the same Left now decries the Health and Care Bill, which reverses the split. The Health and Care Bill does not end the possibility of privatision. But it does end mandatory contracting as a mechanism for privatisation. What the Left fears is corrupt privatisation by the stroke of a Ministerial pen without even the saving grace of transparent tendering. But this would be an abuse of the Bill by a rotten government, not a consequence of the Bill's logic or institutions.

Simon Stevens claimed to the House of Commons Health Select Committee in 2019 that legislation was needed to complete the last 10% of the challenge of integration, having argued that 90% of the moves had at least been initiated by working against the grain of the Lansley Act. While this was no doubt a rhetorical flourish, the point stands, irrespective of the percentages involved. If the integration agenda was a sinister plot to privatise, more would have happened already.

This is not to deny that there have been privatisations (of provision)—for example, Centene's takeover of GP services in London; and, earlier, UnitedHealth's Bettercare. But these developments happened without the HCB. If a government wishes to promote or allow, such developments, it can be done. The criticism of the HCB from the hard Left is that it represents privatisation, which is simply not the case. Ironically this faction also claims that it does this by *ending* contracting (by abolishing

Section 75 of the Lansley Act, which made tendering and contracting for nearly all services mandatory).

The rationale for this belief (to the extent that there is one) is that further privatisation will be enabled by ending statutory contracting, allowing a right-wing government simply to award contracts to its cronies without having to go through the tendering process. But it is of course hugely ironical to see the hard Left bemoaning the demise of the hated Lansley reforms.

Another confusion concerns whether or not the HCB does in fact end the purchaser/provider split. At one level, this is a matter of definition. If ending the split is defined as requiring the complete merging of all separate organisations within an ICS into one organisation locally defined—as in the NHS Reinstatement Bill (UK Parliament, 2019)—then it does not (Roderick and Pollock, 2021). But if ending the split is defined as compatible with separating the planning function (conducted by the ICS itself) and the service management function (i.e. the providers), yet bringing both together in an integrated organisation (the ICS), it is indeed being ended. Furthermore the direction of travel, indeed the very logic of ICSs, is clearly to end it—with the existence of Foundation Trusts, for example, being a matter for later decision, according to the HCB.

Of course it may be that a neophyte Conservative Health Secretary, who yearns for the ethos of the Thatcher reforms, re-strengthens 'self-governing' hospitals—as Sajid Javid confusingly suggested in proposing 'Academy Hospitals'. But this would be a case of *contradicting* the spirit of the legislation, and maybe the letter too. It would not bear out the charge that the legislation completed either a privatisation or market 'conspiracy'.

In Scotland, no one would dispute that the purchaser/provider split has been ended: the Thatcher reforms have long since been reversed, thanks to devolution; there was no Blair–Milburn 'New Labour market' as in England; and mercifully no Lansley mess either. Yet there is still a distinction between the planning arm of the Health Board and the provider services.

Next, the ICS itself is seen by the Left as a kind of rogue, quasi-private organisation. This is a borderline conspiracy theory. In England, the Department of Health and its Regional Teams (RTs) fund ICSs, which then allocate the money to its constituent providers. Analytically, this is similar to what the District Health Authority did pre-1990, when it got

its money from the Region. And never underestimate the ability of 'performance management' to force ICSs to dance to the Regional tune, not least with significant new powers given to the Secretary of State; nor the ability of ICSs, acting under Departmental diktat, to force its constituent providers to dance to a unified tune.

Some on the Left argue that there is no necessity for ICSs to be local, but this depends on one's definition of local—and in any case, is a red herring. The era of the 'one size fits all' District is long gone, and not as part of a right-wing conspiracy. That is the flaw in the Left's well-intentioned NHS Reinstatement Bill: it does seem to imply old-fashioned Districts.

And of course the fundamentalist Left's argument can be turned against itself: even a fully public, integrated NHS *can* be a more efficient instrument for retrenchment and exploitation than a costly fragmented 'market' NHS—as indeed various Marxists argued in the 1970s. That does not mean that an integrated NHS is a bad thing. It just means that it can be abused in the wrong hands.

The purchaser/provider issue is confusing because it means different things to different people. Any healthcare system—whether Soviet, American, European insurance or English-style NHS—has a payer/provider distinction; the NHS has always had to have a planning/management distinction. Automatically calling either of these universal phenomena a 'purchaser/provider split' is either confused or deliberate political rhetoric by either proponent or opponents of particular initiatives to prove a point or spin a yarn.

The NHS always had payers and providers. The practical question, irrespective of the often-misleading rhetoric of markets has always been—at what level do we operationalise this?

Another confusion is around whether the HCB, being the outgrowth of what began back in 2015 as STPs, is the apotheosis of a low-budget, 'rump' NHS. It is undeniable that STPs were a consequence of the cold financial climate facing the NHS in the aftermath of the 2009 financial crisis and subsequent fiscal squeeze. We know this because the government told us that was their origin—hardly a conspiracy, even if a poor political choice.

But the best case against market reform is that it is expensive as well as counter-productive even in terms of its own stated goals. Streamlining services by abolishing the market produces, if it is well-managed, a 'peace dividend', crucial at a time when finances are tight. The HCB was, for the

Conservatives, an admission that NHS markets in general, and Lansley's version in particular, were unaffordable.

The HCB, despite its origin in the Sustainability and Transformation initiative, did not commit the NHS to low funding. A future Labour government can build on the new integrated structure in a different political context if it has the will to reinvigorate the NHS. The Blair government, for example, provided the NHS with its best funding in history, in real terms. It was just a pity that its market fetish and continual tinkering with NHS structures wasted some of that money.

Those who bemoan 'privatisation' via the Health and Care Bill are often unwittingly bemoaning the opposite—a central control that enables the enforcement of agendas which they dislike. There are arguments against an over-centralisation, which have indeed been made against the HCB. But this is a different issue: who does one trust best to run the NHS—Whitehall or localities? Both have their advantages and disadvantages. A corrupt central government can mess up local plans or local services. But a benign central government can rescue them from inadequate local control. There are arguments on both sides, and unless one is driven by the ideology of either local democracy or central control, the decision is often a pragmatic one.

One advantage of the centralisation contained within the HCB, as discussed above, is that the buck will stop with government. Inadequately funded HMOs in the USA became a political scandal and discredited what had been a progressive policy. ICS Boards will soon become the focus for popular discontent at inadequate services (not autonomous provider Boards, to which PCTs for example often tried to pass the buck).

What is more, ICSs' self-evident status as creatures of government will prevent governments from passing the buck to them: at least centralisation of blame allows a more honest debate about the adequacy of the NHS budget. Likewise reconfigurations of services: it will be clearer who instigates and approves these—the former either the ICS or government, and the latter government. I use the term government to refer to the national realm in its widest sense, including NHS England, which is only as independent as government policy and 'mandate' allow it to be.

If there were (say) regional government with legitimacy which ran the NHS, the debate of course alters. The above discussion assumes that the choice is between central government responsibility and local unelected management agencies.

Conclusion: Future Improvements

For those whose suspicion of the HCB is deep-rooted, the following improvements are suggested:

- Make the NHS the 'preferred provider', not using that phrase to indicate that there has been a sell-out to privatisation and the market, but the opposite: that the private sector must only be chosen in particular circumstances, tightly circumscribed by regulation. More: the private sector must be used only to subcontract from a public provider.
- Terms and conditions for staff should be national, to prevent a race to the bottom. National regulation is easier in the framework of legislation which gives the Secretary of State more power than at any time in the recent past, if ever. Critics of the bill from a neutral standpoint or the pro-reform side, not the Left, have indeed criticised it for this reason.
- For-profit private companies should not be represented on ICS Boards, not should individuals with *any* links to such companies. Amendment 25 to the Health and Care Bill, introduced to indicate that conflicts of interest should be avoided, should therefore be strengthened.
- Do not allow any leaks from public money in the form of incentive payments for private providers (e.g. keeping any surplus left over after from meeting its contracted obligations from its budget).
- Use the inherited HCB and ICSs to move towards a fully public NHS, in an improved and less bureaucratic version of the 1974 reorganisation (when Area Health Authorities were quasi-purchasers and District Health Boards were quasi-providers).
- Clarify the relationship between the NHS and the wider public health, through clear links between ICSs and the agencies responsible for public health at the local level, currently local authorities; and re-emphasise health both promotion and health protection, undermined in decades of re-disorganisation. Without this, the aspirations of the Wanless Report (Wanless et al., 2002) will be impossible.
- Ensure that the NHS budget grows enough so that the integration promised by the abolition of the market is compatible with properly integrated, high-quality services for patients. Sustainability and

Transformation funds were previously used to bail out NHS Trusts in deficit. This was *not* the fault of these Trusts. It was a consequence of the 'austerity' from 2010 onwards. The moral is that, if the NHS is to be a viable universal service for the future, it must have adequate resources (Committee of Public Accounts, 2018).

- The NHS budget and the budget for 'social care' are interdependent. The core NHS and new national care service will themselves require integration over time, to prevent buck-passing and budget-shifting.

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PART III

Covid Crisis

This part of the book now addresses the most cataclysmic event to affect British health policy in modern times. The pandemic has shown that issues of NHS reform, the theme of the first two Parts of this book, important as they are on their own terms, are firmly put in their place by wider issues. But it has also revealed the contribution of wider health policy reform to worsening the country's preparedness for a pandemic.

The next chapter provides insight into how inherited health structures and, much more significantly, reckless and chaotic leadership in the UK laid low a country with a proud record in public health in times past (and allegedly even in 2019 the second-best preparedness for pandemics in the world). After two years of the pandemic, the UK numbered among the worst performers in the world in dealing with Covid-19. Boris Johnson, for the first few months of the pandemic, was fond of describing the UK's response as 'world beating'. Sadly, this fantasy was realised in the worst possible way.

Check for updates

CHAPTER 8

Catastrophic Policy: A Reckless Regime

The Covid Disaster: An Initial Summary

The UK (English) response to the novel coronavirus and its subsequent handling of Covid-19 was disastrous. The short version of making this case is simple:

> the Prime Minister was insouciant about the threat from pandemics (Johnson, 2020; Paton, 2020a), arguably negligent in his initial response to Covid—and absent in the crucial initial weeks when a quick response was required, leaving the government rudderless;
>
> the structure for scientific (epidemiological and medical) leadership and top-level influence in the crisis was sharply inadequate; and it took the key scientific advisers too long to get 'up to speed'
>
> throughout the twenty-one months to October 2021, recklessness and a *cod* libertarianism undermined any prospect for a reasonable management of the virus, with the same mistakes being made over and over again; and as a result:
>
> the UK was forced to live with a dangerously high (indeed world-beating) level of Sars-Cov-2 (Covid-19) circulating, forcing the trade-off between the benefits of 'normal life' and health protection to occur at a shockingly

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high level of death and harm to the public, especially the clinically vulnerable and the unlucky. Most of Europe (although most other European countries had not shone in managing the pandemic, although their failures were not as abject as the UK's) went for what Pagel and McKee (2021) called 'vaccine plus' whereas the UK went for 'vaccine alone', leading to more death, disability and risk of further (harmful) viral mutation;

this led to the UK being in a weaker position when confronted by the much-mutated Omikron variant of the virus.

Structure and Agency—A Double Failure

The UK response to Covid showed a toxic interplay between inadequate (political and professional/scientific) structures, inadequate political leadership, poor policy and the stark resulting outcome—death and morbidity on an industrial scale, worse than in any comparable country. Neither was this the result of a meaningful trade-off: failure to manage Covid led to a much worse effect upon the UK economy than 'going early and hard' to contain and/or control it would have done.

In terms of the themes of Parts I and II of this book, the continuous revolution in reform—geared to the NHS in particular, but with a knock-on effect upon health structures in general, which were often uprooted and 'reformed' as a careless afterthought—had undermined public health and health protection capacity. This was for three reasons. Firstly, the particular reforms of the market era (especially the Lansley reforms) dismantled a workable health protection structure, as a direct effect of their structural demolition of, and change to, effective institutions. Secondly, constant change irrespective of its institutional details undermined the stability required to build up and maintain expertise and the authority to influence government, indeed with some of the loss of professional independence from government, reprehensibly, deliberate. Thirdly, the ongoing chaos in structures facilitated a diminution of the status of, and resources for, public health.

The Lansley reforms, for example, initially got a half-cheer for returning some public health responsibility to its traditional home, local government, but it soon became apparent (and the pandemic hammered the point home) that any benefit from this was on paper only. Local government had neither the resources nor influence (vis-a-vis the new

compliant quango, Public Health England) to make much of a difference. Worse, for the first six months of the pandemic, it was deliberately marginalised, indeed kept in the dark, by central government—until a failing approach necessitated a rapprochement of sorts.

The Global Health Security Index, as recently as October 2019, only three months before the novel coronavirus became internationally known, had placed the UK second in pandemic preparedness (Center for Health Security, 2019) (second only to the USA, to complete the irony). External audits which rely upon self-descriptions and tick-boxes about systems are however always vulnerable to superficiality. For the UK's self-audit was self-congratulatory, with complacency probably directly in proportion to the decline in robustness of its health protection structures.

These structures had declined from exhibiting robust professional independence to an unhealthy symbiosis with the politics of the day. Moreover, Exercise Cygnus (2020), warning of ill-preparedness for pandemics (Nuki & Gardner, 2020), which focussed on influenza but containing useful warnings applicable wider, had been shelved by previous Health Ministers. Exercise Alice, seeking to learn from MERS (Middle Eastern Respiratory Syndrome), had been buried.

A few years before, as a result of the Lansley reforms, the Health Protection Agency had been replaced by a more compliant quango, Public Health England. The Health Protection Agency (HPA) with its regional network of laboratories, had been abolished, replaced by PHE and the reduction, to skeleton form, of testing capacity, alongside the emasculation of local government capacity and autonomy despite the rhetoric of returning old pre-1974 powers to local government.

If there were a sliver of excuse for the initial failure of the government to prevent Covid from becoming endemic in the country before the first lockdown at the end of March 2020 (and that would be highly generous, as explained below), then there is no excuse for what became a devastating second wave (from September to February) which, as well as helping to manufacture the British/Kent Covid variant (subsequently called the Alpha variant), killed more people than the first had and less than no excuse for snatching defeat out of the jaws of a victory achieved via vaccination.

The Johnson government and key official scientific advisers did not rise above the diminution of Britain's health protection apparatus: they hid behind it. While the official scientific structures, including SAGE and its associated committees, were revealed by Covid to be inadequate, the

failure of official scientific leadership was notable, although not in the league of the failure of leadership by Prime Minister Johnson and his inexperienced Cabinet.

Another right-wing populist leader in Australia, Scott Morrison, and a social democrat in New Zealand, Jacinda Ardern, were able to take the required action, but Johnson was not. Enter herd immunity (see below), a heaven-sent 'theory' for a self-styled libertarian. The Italian Prime Minister told his Health Minister that Johnson had told him, 'we're going for herd immunity'. Rather than merely being asleep at the wheel, the Prime Minister was actually driving in the wrong direction. Boris Johnson's cabinet, moreover, was content to believe health protection agency heads, brought up on a culture of telling their superiors what they wanted to hear, that Britain was well prepared. But chief scientific advisors were preparing to fight the wrong disease with the wrong strategy until it was too late.

Good leadership was certainly required as a necessary, let alone sufficient, condition for success in coping with Covid, given that the 'health protection state' was broken as a result of forty years of the subjugation of independent, professional public administration to state managerialism and privatisation, ten years of cuts from 2010 to 2020 and a recent preoccupation of key health security agencies (even Public Health England) with Brexit.

But even a basically competent leadership would have apprised itself of the UK's denuded health protection structure and acted appropriately. The counterfactual—a good leader—would have thought something like the following:

> *Testing capacity is threadbare, so we must close borders and quarantine, as we will not be able to rely on catching and containing the virus. And we must act now to beef up testing and protective equipment.*

Scientific leaders also were inappropriately quiescent, taking their cue from what they second-guessed their political bosses to be thinking. According to Professor John Edmunds 'No-one thought it would be acceptable politically "to shut the country down"… We didn't model it because it didn't seem to be on the agenda' (Calvert & Arbuthnott, 2020).

The Prime Minister was either absent at Chevening in the crucial weeks or suggesting, in Greenwich on February 3 (Johnson, 2020) that Britain

should 'shed its Clark Kent spectacles' and resist the 'exaggerated threat of global pandemics'. The official scientific chiefs were dusting off the influenza pandemic playbook (the wrong disease), and registering the threat level at 'moderate' for far too long. And the Health Secretary and Public Health England were believing their own propaganda that Britain was well prepared.

When, by summer 2020, the chief advisors had (unlike Boris Johnson) learned from their mistakes, they continued to support the Prime Minister at many Downing Street Briefings. But despite this loyalty beyond the call of duty, the Prime Minister ignored unequivocal advice for a second lockdown repeatedly. Hoping to find a reason or argument to avoid more lockdown, he even consulted, as a last resort, with maverick anti-lockdown British academics Carl Heneghan and Sunetra Gupta (Calvert & Arbuthnott, 2021)—and also the Swedish Chief Epidemiologist, Anders Tegnell, one of those arguably responsible for what the Swedish King and Prime Minister described as their country's 'failure' on Covid.

When the inevitable U-turn brought the second lockdown, it came two months too late. Six months later, both the BBC and ITV, the UK's two main television networks, reported three separate sources who claimed (and stated they would repeat under oath) that they had heard the Prime Minister say he would rather see 'bodies piled high in their thousands' and Covid let 'rip' than have another lockdown.

A third procrastination, before Christmas, was still to come. After the second, short lockdown ended, cases, hospitalisations and deaths began to soar. Yet Johnson stuck to an inadequate 'regional tier' system of restrictions, by now directly against the advice of his chief scientists. Once again, earlier action would have saved thousands of lives: more than half of Britain's Covid-caused deaths between March 31, 2020 and March 31, 2021 came after January 1, 2021.

It is in this context that we should judge Boris Johnson's claim in January 2021, when Covid deaths reached 100,000 by official figures (deaths of those who had had a positive Covid test and dies within 28 days of that) and 115,000 by the more reasonable measure of deaths with Covid registered as the main cause, that '… we truly did everything we could, and continue to do everything we can, to minimise loss of life and to minimise suffering' (Johnson, 2021; Reuters Staff, 2021).

Professional Advice

The aim here is not to focus on individuals per se, but it is not possible to recount events without naming certain key individuals. Professor Chris Whitty (Chief Medical Adviser for the UK and Chief Medical Officer for England), Sir Patrick Vallance, Chief Scientific Advisor for the UK, and Dr. Jenny Harries, Deputy Chief Medical Officer (England) (later Director of the new UK Health Security Agency) played controversial roles. Whitty and Vallance were reading from the influenza 'playbook' for too long (Calvert & Arbuthnott, 2021). Vallance reflected on herd immunity in a damaging manner (BBC Radio 4, 2020). They acquiesced in the abandonment of community testing. Soon after, Whitty invoked 'behavioural science', to the frustration of many behavioural scientists (Paton, 2020b), to justify late lockdown.

Political reluctance to take tough measures was reinforced by 'professional' advice that such measures would not be tolerated. For example, even in late March 2020, according to Dominic Cummings in his evidence to the Joint Committees (see below) on May 26, 2021, Public Health England was saying that there was 'no way' people in the UK would do 'test, track and trace' as in east Asia. Quite apart from the inappropriateness of a health agency making decisions about broad social matters outside its remit, this was arguably quite false.

However it echoed the stance of SAGE in January 2020 and the view of Whitty in March 2020 that lockdown would be tolerated for only a short time. In November 2021, Whitty was at it again, expressing the view that he worried that re-introduction of restrictions as a result of the worrying new variant of Covid, Omikron, would not be accepted.

Harries, for her part, claimed that community testing for Covid was abandoned as part of a scientific strategy, but it was in fact abandoned because of a lack of capacity to test (which was later admitted, leaving Harris's covering of her political 'masters' embarrassingly exposed). Even this 'lack of capacity' may have been a cover for an adherence to 'herd immunity' for far too long.

Harries also claimed that 'WHO advice on testing is for poor countries' (see UK Prime Minister, 2020); that the UK was well prepared for a pandemic; that there was no evidence that large sporting events were a danger in terms of spreading the virus, less than two weeks before the first lockdown; and that face masks were a 'bad idea' (pointing to some dangers in their use, a different issue).

By now in her new role, promoted to be Director of the UK's new Health Security Agency (a mid-pandemic reorganisation), Harries announced in September 2021 her organisation's recommendations that hospitals in England relax Covid rules to treat more patients. This included an end to testing and isolating patients before planned operations, and a reduction in social distancing and standards rather than enhanced cleaning—for elective services. This sounded more like the agenda of a government seeking to relieve the NHS of pressure than independent professional advice from the agency concerned with health protection.

The corporatisation of public health advice within government seems to have reduced the independence of professional advice. Simon Clarke, a microbiologist from the University of Reading, pointed out that patients with false negative lateral flow tests could end up on wards with vulnerable patients and that corner-cutting in cleaning could well lead to transmission of Covid-19 and other infections. We can also note the replacement of PCR tests with lateral flow tests for vaccinated travellers returning to the UK. Not doing a PCR test meant that genetic sequencing to check for variants would no longer be possible. After the negligence involved in the Delta variant becoming endemic, this seemed a careless step.

Harries also told the Downing Street Briefing of May 28 that it was 'on the cusp' whether the Delta variant was taking off or that there was a rise in cases merely because more cases were being hunted, having recently claimed that the few cases were being subject to aggressive contact-tracing and would be contained. Later she stated that cases looked as if they were 'starting to plateau out'. She went on to state that the increased cases 'were not generally translating into increased cases of hospitalisation and definitely not into deaths'. This was wholly mistaken. The very next day, Sir Tim Gowers said that things could turn bad 'very, very quickly' if restrictions were lifted prematurely. It seems that those who were able to draw accurate conclusions were those on the outside of government or its quangos.

'Following the Science'?

The government hid behind the slogan, 'following the science' (sometimes 'evidence'), until it was apparent even to its most enthusiastic supporters that this was an unsustainable claim—either wrong or unfalsifiable. Indeed Ashton (2020) argued that the government had done nothing recognisable from two centuries of public health knowledge.

But even if one accepts the dubious claim that the government was 'following the science': what sort of science argues that disaster has to strike in order to be measured in all its calamity so that 'evidence' can be acquired to justify action.

The official threat level from the novel coronavirus was kept at 'moderate' long past the point at which it was undoubtedly severe. Moreover the strategy adopted was eminently unsuitable, as the nature of the disease was known by early January, from information coming out of China, and published in The Lancet later that month. It is true that the Wuhan municipal government concealed the threat for a crucial number of days in December 2019, and the Chinese state's secretiveness more generally was in evidence—briefly but for a crucial few days in terms of travel. But this is a separate issue from a failure by another country—the UK—to absorb extant data when it became available from Chinese scientists and then (later, but long before the UK government took it seriously) the World Health Organisation.

'Kissing Up' to Government?

We may add to this story a poor performance from Public Health England, a tightly-managed quango in charge of Britain's health protection since 2012 following the NHS reforms of 2012. Britain was well prepared for dealing with such threats, it boasted on its website, telling its masters what they wanted to hear. The subjugation of professionally-led, independent agencies to political control, considered convenient to Ministers since the days of Mrs. Thatcher, and the misleadingly-named 'new public management', was now taking its toll.

For Britain was extremely ill-prepared. There was a poor capacity to test; reduced capacity and compromised autonomy of local public health, and the latter's subjugation to the regional and national offices of a politically constrained Public Health England; inadequate NHS provision in terms of bed numbers and staff; minimal stockpiling of Personal Protective Equipment and an already-stretched social care, soon to be turned toxic through receipt of infected patients from over-stretched hospitals.

Herd Immunity

It was assumed by the official scientific chiefs that there would be a 'second wave' of Covid infection, hospitalisation and death even before the first wave had registered, using the influenza playbook. It was therefore deemed necessary to allow the first to create some 'herd immunity' while 'flattening the curve' to mitigate the effect upon hospitalisation and 'protect the NHS'.

The assumption was that only by allowing the virus to spread in a controlled way could an inevitable second wave be reduced in severity. This assumption was rejected by many reputable scientists at the time, and one year later, inspection of the 'second wave' graphs of countries which had the highest first waves shows it to be wrong. Brazil, the UK and the USA are countries which (for one reason or another) allowed a first wave of Covid significant leeway and went on to suffer crippling second waves. These three countries, not coincidentally, exhibited variations on the theme of chaotic leadership.

The vexed question of herd immunity bedevilled Britain's approach for far too long. It is clear that, at the very least, the option was not only seriously considered but also favoured. Its logic underlay the 'strategy' of 'contain, delay, research, mitigate'. This was copied from the influenza playbook.

Yet this in practice was a mantra, not a strategy. The first element—containment—received only lip-service: the attempt to contain was both perfunctory and hampered by the stripped-out testing capacity. The second—delay—was misconceived, based as it was on the wrong assumption that allowing controlled spread would reduce the severity of the supposedly inevitable second wave. The third—research—was either wishful thinking (something will turn up) or a truism (research is always useful). Settling on the fourth—mitigate—led to a failure to minimise and eradicate Covid in summer 2020.

Herd immunity (as a policy) was a scientific blunder and a waste of time in equal measure. Matt Hancock, Health Secretary until July 2021, denied in 2020 that it was a policy as opposed to a theory, but this claim has not survived later revelations.

One year later, when the true death figure was probably around 150,000, the percentage of the population which had Covid was little more than 20%. Herd immunity, even assuming that having had Covid rendered one both immune and also unable to transmit the virus (both highly dubious assumptions), was a nonsense a priori as well as ex post facto.

A strategy based on treating Covid de facto as what rogue Brazilian President Bolsanaro called a 'little flu', cost the UK dear. Even a student of rudimentary arithmetic could easily see through it: if Covid only killed 1% of those who caught it, then achieving a herd immunity of 60% of the population would still be likely to mean c.400,000 deaths. (What is more, 60% was a likely gross underestimate; and once Delta took hold, herd immunity was more likely to require a % in the high 90s.) Moreover, pretending that the government could combine an 'open' society with protection of the vulnerable through shielding—the view of maverick Professors Carl Heneghan and Sunetra Gupta domestically and the Great Barrington Declaration (funded by the 'libertarian' Right) internationally—was nonsense.

Of course one must ultimately blame the political leadership, even if the official scientists should rightly be criticised: scientists advise and politicians decide—even if the 'executive summaries' of the UK Government's Scientific Advisory Group for Emergencies (SAGE) minutes did not communicate the disquiet of scientists such as Professor John Edmunds.

Confirmed revelations from the Prime Minister's estranged former Chief Adviser have made it clear that herd immunity was the policy. Dominic Cummings revealed to a joint hearing by the House of Commons Select Committees on Science and Technology and Health and Social Care (2021), on May 26, that he had briefed the Prime Minister regarding the consequences of *continuing* with herd immunity in his study on the morning of March 7, 2020. Cummings had sought advice on herd immunity, about which he became increasingly worried, from Professor Tim Gowers of Cambridge University. On May 28, extracts from Gowers' reply to Cummings were published (www.guardian.com, 2021). These reinforced how seeking herd immunity by September 2020 (even if possible, which it clearly was not) would have led to carnage in terms of deaths and untreated patients on an industrial scale, even by the most optimistic assumptions.

The only option at this stage was a rigorous and immediate lockdown, with the prospect of more to come, in order to contain and minimise Covid. There was no 'middle way'—of pursuing herd immunity more moderately is by 'flattening the curve' of infection to protect the NHS, an approach which both Whitty and Vallance had repeatedly hammered home in their public presentations with Johnson at Downing Street. As Gowers said, 'In particular, there is no "middle approach" where we get to herd immunity in a controlled way—to achieve the control we would have to apply a large amount of social distancing anyway, and for much longer than would be needed if we went for a pure social-distancing approach'.

In other words, there would be long-standing semi-lockdowns and yet death and illness rates far higher than a Covid-minimisation policy would entail. One might add: since poorly-controlled Covid would mean a majority of the population living in fear and failing to consume as normal, the economic harm of lockdown would apply in any case. And in the absence of mandatory control of behaviour through full lockdown, an irresponsible large minority would ensure that Covid spread in any case.

'We Did Everything We Could'?

It was only when Imperial College's modelling for WHO (Ferguson et al., 2020) caused panic stations that lockdown came on the agenda. This was followed, a few weeks later, by a realisation, too late, that mass community testing would have to be revived, not least as a strategy to exit lockdown.

Lockdown, when it was announced on March 23, 2020, was too late, and ended too soon. Previous Chief Medical Officers had been more forceful than Whitty, even with stronger Premiers than Johnson. When CMO, Donald Acheson, a quiet man, had nevertheless not hesitated to insist to Margaret Thatcher that AIDS must be taken more seriously in the 1980s; and he succeeded. Former CMO Liam Donaldson is apparently perceived (in the institutional memory of government), unfairly and only with hindsight, as having 'overreacted' to a past threat. Perhaps Whitty feared being seen to overreact.

As with the first lockdown, the second also came far too late (in November 2020), as the government had disregarded what by now was unequivocal scientific advice to have a 'circuit breaker' lockdown in September. But the scientific chiefs still did not demur: on one occasion, the Chief Scientist even defended the disregarding of his own advice to

have a 'circuit-breaking' lockdown. When challenged to repeat his advice at a Downing Street Briefing in October the week after it had been disregarded, he claimed that the moment for action had passed. His rationale was that, with time having been lost, Test and Trace would be unable to cope with a higher quantum of infection. But this was a logical dead-end. If cases were now to be as high as this, then surely a lockdown was required for even more compelling reasons i.e. the threat to the NHS and the mounting death toll.

Even assuming that Test and Trace coped, a heroic assumption, then if compliance with isolation was not forthcoming, it would be in vain. And compliance was a problem throughout the pandemic. One example typified the problem: Geoff Barnes, deputy public health director at North East Lincolnshire Council, said the area was seeing a regular pattern of outbreaks within the low-wage economy—including workplaces such as food factories, where people cannot work from home and it is often more difficult to maintain a Covid-secure environment. Barnes told BBC Radio 4's Today programme that many workers were also agency staff or on zero-hour contracts, meaning some could not afford to self-isolate. Moreover, 'We think that people are just avoiding getting tested sometimes when they have mild symptoms, or may continue to go into work when they've been in contact with someone they know who's had Covid', he added. At no stage in the pandemic did the government take 'isolation' seriously in its implementation.

We may also note that the Chancellor of the Exchequer Rishi Sunak's 'Eat Out to Help Out' scheme over the summer of 2020 caused a Covid spike (Fetzer, 2020) as did the movement of students from September to December 2020 (Office for National Statistics, 2020; Telegraph, 2020). The government was simply not focussed on controlling Covid, at all stages seeing a false, or short-termist, trade-off between that and 'the economy'.

Over summer 2020, significantly lower infection figures, with related reduced hospitalisation and minimal deaths, could have been used to minimise, not mitigate, the prevalence of the virus. Scotland came close to eliminating it, but its limited autonomy meant that, like the rest of the UK, it was bound by England's looser approach. With transport and welfare policy being central UK government responsibilities, the limited autonomy which Scotland and the other home countries had in dealing with Covid was undermined.

The inevitable second lockdown was eventually called for November 3. Announcing it on the prior Saturday evening, after a leak allegedly to prevent it being delayed further by the Prime Minister (Calvert & Arbuthnott, 2020). Johnson was perceptively subdued and his body language suggested disengagement from what was now being announced. Only days before, he had taunted Sir Keir Starmer, the Leader of the Opposition, with wanting to close down the country.

Such reticence predominated throughout the pandemic. Before the second lockdown and then between the second and eventual third, which began on January 2, an inadequate 'Tier' system was instituted, with different areas of the country subject to different restrictions. The first was notably weak, with pubs allowed to open even in those areas worse afflicted with Covid if they served meals. (This led to arguments more suited to surreal comedy about what constituted a 'meal': was a hamburger a meal if accompanied by chips; and what about salad?) The second Tier system, between second and third lockdowns, was marginally stronger, but—instituted after the second lockdown ended too soon—it was overwhelmed by rising infection rates, hospitalisation rates and deaths on a huge scale.

Hence the third lockdown immediately after the New Year. The Prime Minister had once again taunted Starmer, this time with wanting to 'cancel Christmas', only to be confronted with a need to U-turn once again. This was chaotic. Schools had opened for one day only in January, to be closed again in panic. Gavin Williamson, Education Secretary had recently gone out on a limb about keeping schools open, even threatening London Boroughs with legal action if they closed early for Christmas in response to the worsening Covid data. He survived at the time but was sacked later, on September 15, 2021.

Vaccination

Only the vaccine saved Britain's bacon. Out of desperation, Britain's Medical and Healthcare Products Regulatory Agency (MHRA), having already approved the Pfizer BioNTech vaccine, hastened the approval of the UK's own Oxford AstraZeneca vaccine despite less convincing trial data. At this time, many other countries considered this data not to be convincing enough. Later data however gathered from both usage and a bigger trial showed good results, including for older people who had been absent from the first main trials. Later still, AstraZeneca was shown

by larger-scale population data to have performed less well than Pfizer and Moderna (see below).

It was claimed by government Ministers and supporters that only because of Brexit was quick action on the vaccine possible. This disregarded the fact that when the UK approved first Pfizer then AstraZeneca, it was still subject to EU rules in the transitional year after Brexit, which only ended on December 31, 2020. Individual EU countries could approve a medicine or vaccine on a national basis in emergency situations (e.g. a pandemic). Hungary for example approved the Russian Sputnik vaccine.

An embarrassing moment was provided by Education Secretary Gavin Williamson, who claimed that Britain's medicines regulator the MHRA was better than Germany's, France's and Italy's because Britain was 'a much better country than every single one of them' (Williamson, 2020). It was true nonetheless that the EU had hardly shone so far in terms of its vaccine procurement. It had sought to persuade member countries to sign up to its centralised procurement, which was poorly handled and responsible for vaccine delays for which the EU sought to blame others. In addition, many European countries were among the world's poorest performers on Covid overall.

Nevertheless by autumn 2021 much of (western) Europe had caught up with, and overtaken, the UK in % of people double vaccinated. The latter having only reached 67% in the UK by mid-October. That said, by the end of January 2022, the UK had reached the figure of 80% of those eligible double vaccinated; and 75% of eligible adults had received their booster. This was all good news, and none of the following observations are intended to detract from that fact.

AstraZeneca was never approved in the USA and was eventually withdrawn for the under-30s in the UKs, as well as being wholly unused for boosters except in the cases of individuals who could not take other vaccines for medical reasons. Lest 'anti-vaxxers' draw the wrong conclusion (their speciality), clearly having AstraZeneca rather than being unvaccinated was the right thing to do—a 'no brainer'. All approved vaccines, as well as new therapeutics, represented success. The discussion here is about the success of different vaccines *relative to each other* and the situation which the UK confronted in *having little choice but to hasten the process of approval.*

By autumn 2021, data showed that AstraZeneca's ability to reduce hospitalisation (and therefore perhaps death) fell from 90 to 70% by 20 weeks after the second dose. (This was before the Omikron variant became dominant i.e. it was when hospital cases were more severe on average than when Omikron, seemingly somewhat milder, had superseded Delta.) Protection against symptomatic illness fell from 65% up to three months after the second dose to 45% six months after the second dose for the AstraZeneca vaccine, as compared to a fall from 90 to 65% for the Pfizer/BioNTech vaccine. Protection against hospitalisation was estimated to fall from 95 to 75% for Oxford/AstraZeneca, as against a fall from 99 to 90% for Pfizer/BioNTech.

Could the widespread use of AstraZeneca for first and second jabs in the UK be *one* of the explanations for the higher-than-expected hospitalisation and death rates prevailing in the autumn of 2021? This perhaps went a part of the way to explaining the following worrying statistic: in October 2021, 4409 people over 50 were admitted to English hospitals after testing positive for Covid, despite having had two doses of a vaccine. And 2148 men and women in that age group lost their lives.

To be fair, the worsening picture in terms of deaths by November 2021 was likely to be more as a result of the *waning* of protection from (any of the) vaccines, now believed to occur by five months after the second jab. Even when the Omikron variant was shown to be not so effective in a double dose, acquiring a third (ie booster) dose was shown to reduce the risk of hospitalisation by 90%.

Nevertheless, we may note that the AstraZeneca vaccine was quietly shelved when it came to the booster shot (third jab of the vaccine) in the UK. Boosters were to be of either the Pfizer or Moderna vaccines, with AstraZeneca only for the very few who could not tolerate Pfizer or Moderna for a medical reason. This was clearly justified by the data. What was a great pity on a worldwide scale was that adverse publicity about the (very small statistical) risk of blood clots from AstraZeneca's vaccine led some poorer countries and individuals therein to decline to use it when the alternative was no vaccination. For clearly being vaccinated rather than remaining unvaccinated was a 'no brainer', especially since the chances of getting a blood clot from having Covid were much higher than the chances of getting one from the vaccine.

The UK government's one major success in Covid times was its vaccine policy—*order lots and order early*. It was its prompt action in placing orders from different companies for as yet uninvented products which

enabled the UK to get out of the blocks early. So why did the government act quickly in this respect but drive in the wrong direction on other matters? One explanation is simply that it did the right thing. A supplementary explanation points to the fact that placing orders is easy, whereas designing and implementing risk-averse health security policy at short notice (border controls; effective quarantine; beefing up inadequate testing capacity rather than suspending testing; enforcing strict lockdowns; enforcing isolation of people who might have Covid) is difficult.

Delta

In March 2021 briefly, it had seemed that vaccination was going to be even more of a game-changer than it was—as cases began to fall and these translated into very small numbers of deaths by early summer. Yet the government's failure to take seriously the threat from India, for opportunistic and reckless reasons once again, of what came to be called the Delta variant, stymied any attempt to contain Covid. Instead, it became virulent once again; the government compounded the problem by going ahead with the irresponsibly-named 'Freedom Day' on July 19, 2021.

Despite India having much more Covid absolutely and relatively than its neighbours, it was not, unlike those neighbours, on Britain's 'red list' of countries from which arrivals had to quarantine mandatorily in hotels. That is, not until it was too late to prevent the import, and community spread, of the Indian variant, with three mutations, one of which became serious in terms of spread capacity as well as relative lack of susceptibility to the 'great British vaccine'. Furthermore, the UK's habit of placing countries on the red list too late was supplemented by its habit of allowing too much time between designating a country 'red' and beginning mandatory hotel quarantine. A rush of British Indians to return to the UK in this intervening space of time worsened the mistake of placing India on the red list far too late.

Public Health England (PHE) had initially said that there was 'insufficient evidence' to indicate that any of the variants recently detected in India caused more severe disease or made current vaccines any less effective and that scientists were carrying out laboratory testing to better understand the impact. The story is regrettably one of another poor

performance by Public Health England, by now part of the new (at least in name) UK Health Security Agency. Even when 70 cases of Delta had been identified, with some not able to be linked to travel, Dr. Susan Hopkins said that there was not yet enough data to classify it as a 'variant of concern', and that it was 'too soon to decide if India should be put on the travel "red list"'. Was Hopkins bending to political *diktat* or being complacent? Quite apart from the fact that this number of 70 was likely to be a severe underestimate (shades of March 2020), the fact that—once again—evidence was required of irrevocable spread before action could be taken to prevent the spread (of an *at least potentially* dangerous variant) showed that (again with shades of March 2020) we were back to the idea that we had to experience disaster in order to acknowledge it.

It seemed that the government and its compliant scientists could not escape this mindset: we were to see this approach yet again with the Omikron variant in November/December 2021. And then, thanking their lucky stars that Omikron was not worse than it was (although temporarily death rates reached levels which most countries would not tolerate), the UK government ended all restrictions for England too soon, and sooner than the rest of the U.K.

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Beyond the shortcomings of individual politicians in tackling Covid—which were massive—the response to Covid in the UK was retarded by critical failures in both policy and implementation. Some of these were facilitated by the loss of a public health focus over the decades of 'market reform' (Hunter, 2020), leading to the diminution and in some cases disappearance of successful public health functions (Hunter et al., 2010). Others were more indirectly facilitated by the culture of the 'new public management' (NPM) (Ferlie, 2017) to the extent that the latter undermined the status of independent professionalism and wider measures of value than targets which were either short-term or mechanistic or both. The (partial) supersession of NPM may improve matters for the future, but too late for the Covid-19 pandemic.

What is more, we have arguably seen the de-politicisation of public health in a bad sense (i.e. removal of its political centrality in society) at the same time as the further politicisation of policy, also in a bad sense i.e. governance by slogan, soundbite and immediate 'solution' without proper reflection.

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CHAPTER 9

Living with Covid?

Many scientists had been arguing as far back as December 2020 that what was needed was a proactive strategy to eliminate Covid altogether. In the UK, Independent SAGE had been formed earlier in despair at the government's and official science's handling of the pandemic. It was chaired by former UK Chief Scientist, Sir David King and included many prominent experts such as Professors Anthony Costello and Gabriel Scally (who devised clinical governance with his colleague, former Chief Medical Officer Liam Donaldson). This body embraced that view robustly but to no avail.

By summer 2021, the third major episode of reckless complacency had left Britain in the throes of a 'dangerous and unethical experiment' which saw Covid prevalence reach 50,000 new registered cases a day (the actual figure probably therefore being two or three times that). As a result the Office for National Statistics reported on October 6, 2021 that 1.1 million Britons were estimated to have 'long Covid' in August 2021. The number of people in hospital with Covid reached more than 8000, and even after some decline to just below 7000, the figure was rising again by October 6th, reaching 9000 later in the year.

In this context, 'Freedom Day', July 19, had forced Britain to pretend that 'normality' was restored at a much higher level of serious illness (both acute and chronic) and death than was necessary. It can be argued that Johnson's negligence on three major and many minor occasions since the

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beginning of the pandemic had condemned Britain to this skewed version of 'normality' if the latter were even (or ever) to be attempted. This is the pessimistic way of interpreting Johnson's plea regarding Freedom Day, 'if not now, then when?'.

The government sought to spin a better picture than was the case. On the BBC Radio 4 Today (2021) programme, new Health Secretary Sajid Javid claimed that prior to the vaccinations, 25,000 Covid cases a day were giving rise to about 500 deaths but that the ratio now was only one-thirtieth of that. This was wrong. Javid ignored the fact that there is a delay between infection and death, when he claimed that the current 7-day average of 25,447 daily cases was now producing only 18.14 deaths. Those 18 deaths in fact were correlated to cases reported weeks before. If we assume that deaths occurred on average as a result of cases reported 16 days previously, there had been 9109 cases then. So the incidence of deaths to infections is not reduced to one-thirtieth of what it was, but to one-eighth (Sexton, 2021). Javid's phoney statistic, what is more, came from a time of a low death rate. Deaths from Covid had reached between 200 and 300 by the beginning of November.

Subsequently, it was misleadingly claimed that it was necessary now to 'learn to live with Covid' and for people to take personal responsibility for managing risk. But even if one accepted that it was necessary to 'live with Covid', then at what level? Mainland Europe did not keep out the Delta variant once it was incubated and spread, significantly by the UK, but it did not give up the attempt to reduce prevalence levels as did the UK/England. The Johnson government however—part-deliberately and part-fatalistically—let the Delta variant rip.

In part, this was an attempt to combine the discredited policy of herd immunity (now focussed unequivocally on young, unvaccinated people) with vaccination, in an approach called 'hybrid immunity'. In part, it also stemmed from the Prime Minister's unwillingness to risk popularity and offend his own 'libertarian' instincts by maintaining *any* restrictions. As a result, the levels of Covid consequent upon this approach meant making individuals responsible for social risk.

What such a strategy did not admit to was the fact that individuals' risk calculations were only the tip of the iceberg: man makes his own history but not in circumstances of his choosing. The government lumped together harmless or minor restrictions such as mask-wearing and social distancing with more intrusive restrictions such as lockdowns. It represented *all* restrictions as 'infringements on freedom', and therefore

guaranteed higher levels of Covid than necessary within which individuals had to balance the risk of contracting or passing on Covid and eschewing (for example) public transport, attendance at work or even shopping.

The government spoke with a forked tongue. It appealed disingenuously to 'mental health' and 'non-Covid illnesses' to deprecate lockdowns. But it did not mention the much greater threat to 'mental health' of forcing the vulnerable, risk-averse and (those retrospectively discovered to be) unlucky to swim in a restriction-less sea of Covid. Nor did it admit, if it even knew, that it was *high levels of Covid*, not *lockdowns*, which prevented people accessing health care for other illnesses.

Professor Robert West, of the government's own Scientific Advisory Group for Emergencies (SAGE)'s behavioural science subgroup, observed that, 'What we are seeing is a decision by the government to get as many people infected as possible, as quickly as possible, while using rhetoric about caution as a way of putting the blame on the public for the consequences' (*Guardian*, 2021).

In other words, if things went wrong in terms of both health outcomes directly and yet more extreme pressure upon the NHS, then the public would be the fall-guys. This was brazenly disingenuous: herd immunity *needed* Covid to spread, but the government was too cowardly to admit to responsibility either for its spread or for the double-edged 'fact' that people had to make their own decisions about risk but at far too high a level of Covid in society.

Chief Medical Officer Chris Whitty's view was that it was better to get the latest peak of Covid over before winter 2021/22. This view was that, if the spread were damped down 'too soon', Covid would be suppressed only to rise again and spread more easily in winter, perhaps combined with a flu epidemic (flu having been at negligible levels the previous year because of Covid restrictions preventing it spreading).

But this view, as well as dovetailing perfectly with the Prime Minister's priorities, relied on a risky judgement as to when it was best to let Covid circulate, a judgement which Whitty and colleagues had got plain wrong in early 2020, bolstering an already-reckless Prime Minister in grievously delaying the inevitable first lockdown.

Meanwhile, the UK had been ahead of the game with vaccination early in 2021, but had subsequently slipped. In particular, failure to roll out a programme for the under-16s meant that inter alia schools returning contributed to the virus circulating at a much higher level in the UK, added to the complete abolition of restrictions in England much earlier

than in the other large countries of Europe as well as than in the rest of the UK. This did not stop the government boasting of its world-beating vaccination programme. Looking forward to February 2022, we may note that Johnson, now desperately fighting to save his Premiership in the face of accusations of lying to Parliament, was still repeating another lie—that Britain led Europe in vaccination and booster jabs. It did not. It was fourth, behind Italy, Denmark and Malta, even in the latter.

By early October 2021, the rolling seven-day average of daily (actually tested) cases per million people was above 500 in the UK, below 100 in Germany, about 70 in France (which only a month before had more than half the UK level of cases) and less than 50 in Spain. Even more significantly, the death rate in the UK *after* vaccination was 1.6 per day per million people, twice that of Spain, three times that of France and two-and-a-half times that of Germany.

Add to this the NHS's (lack of capacity): the UK had 246 hospital beds per 100,000 people, whereas Germany had 800, France had 591 and even Italy and Spain had clearly more than the UK at 314 and 297. This data helps to explain why Germany, for example, has a much better case-to-death ratio for Covid than the UK, as does Japan and a number of other countries.

Thus for Whitty and Chief Scientist Patrick Vallance to legitimise, indeed argue for, Britain's 'exit (from restrictions) wave' of Covid to occur earlier, before winter, *without* insisting upon the maintenance of the less onerous restrictions (masks; social distancing; vaccination as a condition of employment and indoor hospitality) was arguably reckless.

Again, the UK was being required to trade-off 'freedom' and health at an unnecessarily high level. Even if past major mistakes (most recently, the mass import of the Delta variant from India) made the UK's task in keeping levels of the virus down more difficult, simply to give up the attempt, while in character for Boris Johnson, was arguably negligent on the part of professional medical and scientific advisers. On 15 September SAGE warned that hospital admissions could reach 7000 per day and called for restrictions 'now'.

Whitty, as one of the coordinators of SAGE advice, had been publicly silent when 1200 globally-influential scientists backed a letter to the Lancet (Gurdasani et al., 2021), the leading British medical research journal, condemning the UK's 'dangerous and premature' plans as unethical and dangerous for the whole planet (CNBC, 2021) and expressing astonishment at how far a world-leader in public health had fallen, despite

the scientific advice available in the UK. A major worry was the export of variants across the world from the UK, along with expedient states in the US, and expedient countries globally, legitimising lax policy by following the UK.

The government was determined to end restrictions on the timeline (save for a fortnight's delay) which had been agreed for the less-infectious Alpha variant. In other words, it was dishonestly arguing that the ending of restrictions was scientifically justified even though the playbook it was using was now obsolete. The government was behaving as if Covid had been tamed. The reality was that many citizens came to believe that 'the pandemic was over'; those who knew it was anything but were forced to live in a parallel universe; and meanwhile, the UK was not only 'running Covid hot' but exporting it widely as a result.

And just as the government had lost the chance to keep Covid out or under control; just as it had failed to keep Covid at a minimum level over summer 2020; just as it had lost the chance to keep Covid under control when the Alpha variant was tamed by letting Delta rip: it now, in December 2021, saw the Omikron variant join Delta, supersede it and run rampant. At one stage, Britain's daily measured case numbers reached 200,000. It was estimated that the daily case rate over the Christmas vacation of 2021–2022 reached 500,000. A death rate (seven-day average) of 300 per day was normalised and hospitalisation reached a maximum of c.20,000 in hospital.

Professor Andrew Dobson (2021) pointed out the irresponsibility of 'running Covid hot' as follows, 'New strains of Covid mainly appear by random mutation. The rate at which new strains appear is directly proportional to the number of people infected. Only strains that are more transmissible than current strains will spread; those that are less transmissible cannot compete with current strains. If you halve the number of people infected, it will take twice as long for a more transmissible strain to appear. If you reduce infections by 90%, it will take 10 times as long. More transmissible strains always increase the level of herd immunity needed to achieve control. If you drop all restrictions of control of Covid on 19 July, then you will increase the rate of emergence of new strains, and set the UK up for a perfect winter of discontent'.

Nick Triggle (2021), one of the BBC's health correspondents, had reported as regards 'Freedom Day' that, 'The logic [of ending restrictions] - along with the benefit of ending restrictions that themselves cause harm to health - was that it was better to have the rebound in infection,

the so-called exit wave, in the summer. It was felt the increase in the spread of the virus would be mitigated by the better weather, meaning more time spent outdoors, and would avoid the winter crunch when pressure on the health system increases across the board'.

This view was allegedly backed up by a modelling exercise (Chapman et al., 2021), the results of which (it was claimed) showed that the UK was in a better position to withstand another wave of Covid. This was however highly contentious. Modelling what might happen if countries' unexposed populations were wholly exposed to Covid 'now' did not mirror reality in any way: this simply would not happen, either without or (especially with) restrictions as necessary over winter. European countries facing a new wave had no intention (unlike the UK) of 'wholly exposing' their populations to Covid. Instead, they planned to ramp up vaccination, including boosters for those whose time had come to be 'topped up', while holding the line through renewed restrictions.

What is more, the lead author of that modelling, which suggested that the UK was in a good position in terms of potential hospitalisation 'if everyone were exposed to Covid right now', warned that such research should not be seen as a guarantee that the UK would escape the winter without seeing a surge in cases. 'We may be in the strongest position - but we could still see cases double and that would cause problems'. (This was of course a prediction before the rise of the Omikron variant.)

To argue both that the UK had more immunity as a result of opening up (i.e. deliberately *more* infection) and yet also that opening up in summer had led to *less* infection (than would a later opening-up) seemed bizarre. The logic, if such there was, seemed to be that, in summer, immunity could be acquired through Covid being transmitted among the less vulnerable population i.e. the younger and healthier who were at less risk of contracting Covid seriously—with less risk of them passing it on to those more at risk (e.g. their parents and grandparents) than in winter when more time was spent indoors. This involves the assumption that acquiring the immunity among the younger and healthier in summer would lead to less presence of the virus in that cohort in winter.

But if those more at risk were vaccinated *and* 'boosted' as necessary, then this argument seems to fall down. And indeed the Imperial College modelling (Imperial College London, 2021) on the basis of which CMO Chris Whitty made his controversial pronouncement that July 12 was the right time to unlock, did *not* include the assumption of the older

and more vulnerable having received a booster. Unlocking in summer—especially in the UK at a time when Delta was rife and Ministers were over-optimistic about the link between cases and hospitalisation/deaths being 'broken'—instead 'normalised' a higher hospitalisation and death rate than most other Western European countries would ever be prepared to accept.

The UK had started vaccination earlier than most of Europe, and (therefore) had to be earlier with the booster programme. To the government's credit, this was a success, warts and all. But countries which had overtaken the UK earlier in terms of double vaccination, such as Spain, Italy and even France, and which had retained the more minor 'restrictions' throughout the second half of 2021 had seen much lower rates of Covid, hospitalisation and death than the UK.

The argument that they had merely postponed the misery gained traction in the UK, but this line of reasoning was contentious to the point of hubris. For the European countries which were now being 'spun' as Covid laggards by comparison with the UK had mostly avoided the high hospitalisation and death rates which the UK had seen from June right through to December. If their Covid rates were now rising (yet even so, in only a few cases to a higher rate than in the UK e.g. Austria and the Netherlands, with Germany on the cusp), then they aimed to control these via lockdowns and restrictions pending more primary vaccination and boosters—even compulsory vaccination, in Austria. It was complacent to imply that the UK's net death and serious illness rates would end up better in the long run.

There was another serious consequence of 'running Covid hot'. The continuing pressure on the NHS meant that the government's designation of it as 'coping' was a controversial one. Consultations for outpatient appointments were delayed badly; waiting times for many procedures after consultations were lengthened significantly; and even emergencies were seriously affected: ambulance times, waits in Accident and Emergency for treatment and waits for a bed once seen were causing deaths daily.

It was estimated that, as well as the deaths from Covid (running at more than 1000 a week in a 'good' week, right to the end of 2021), there were 10,000 excess deaths from *other, non-Covid causes* since the abolition of restrictions on 'Freedom Day', July 12, 2021. Office for National Statistics data showed there were 20,823 more deaths than average since July. 11,531 involved Covid, meaning there were 9292 deaths from other diseases (ONS, 2021).

Even the *Daily Mail* (2021), a right-wing newspaper which had seemed to oppose lockdowns, pointed out the serious consequences: 'There were some 964 extra deaths in private homes in the week to November 5, the latest available, which was 40 per cent above the five-year average. There were also 548 extra deaths in hospitals, 12 per cent above average, and 155 excess deaths in care homes, seven per cent above average. It has been suggested that deaths at home have risen because more people were choosing to die there. But some experts fear it may be because terminally ill people don't want to go into hospital in case they catch the virus'.

Yet the barren idea that it was lockdowns (not *Covid* per se) which damaged health was used as one of the justifications' for ending restrictions on Freedom Day. Running Covid 'hot' was so much worse, however, and now it was becoming evident. Not all the excess deaths from other causes would necessarily be due to NHS delays, but many were. Equally, not all NHS delays are due to Covid, as staff shortages owing to Brexit and other factors may also have contributed. But pressure from Covid, especially in the worse-affected hospitals, was significant, and even staff shortages were significantly worsened by the high prevalence of Covid (absence through self-isolating and Covid illness; absence and resignation through stress; difficulty in recruitment).

A government which had been so keen to claim that 'health' and the need to prioritise other illnesses was a reason for ending lockdowns et al. was strangely silent when it came to this consequence of its recklessness.

If the justification for ending restrictions were the economy, that also was a serious error. Prime Minister Johnson gave misleading data: he claimed that Britain's growth to mid-2021 was the strongest of the G7 countries. But that was only by taking as the baseline the winter of 2020/21 when Britain was known as 'plague island' (Johnson, 2021) owing to the prevalence of Covid and the (eventual) longest lockdown to date. Using the quarter from October to December 2019 (i.e. the last pre-pandemic quarter), Britain was fifth equal out of the seven G7 countries, with only Italy worse. Research moreover had suggested that the worse a country's record on Covid was, the worse the economy would be hit. To put it the other way around: there was not a trade-off, but instead a positive correlation between tackling Covid properly and protecting the economy (Oliu-Barton et al., 2021).

Irrespective of the economy, there had been a lack of ambition as regards driving Covid down to the minimum possible level for succeeding months and years. It was predictable that Johnson would see eradicating it as incompatible with Britain being a global trading nation, unless it were eradicated elsewhere in the world. But of course it would be possible to be more ambitious, by having quarantine hotels for all travellers and lateral flow tests for lorry drivers importing goods—until vaccination globally was achieved, not for ever. Indeed it would provide an impetus to achieve the latter.

One could say more: just as in 2020 China was the root cause of Covid spreading throughout the world yet protected itself, in 2021 England saw Europe increasingly swamped by its Kent Covid (Alpha) variant and the Delta variant which it exported while (unlike Europe) seeking to protect itself through what became de facto a 'vaccination only' policy. Failure to minimise Covid rather than mitigate is internationally selfish as well as nationally risk: the more Covid is prevalent, the more likely mutation is to occur; and the more mutation, the greater likelihood of more infectious and/or harmful strains.

The government was right to praise the invaluable role of vaccines. But they were wrong to use that as an excuse for not continuing to run complementary 'non-pharmaceutical interventions' (e.g. mandatory masks, mandatory distancing and *mandatory* vaccination).

Unfortunately the government of Boris Johnson, by February 2022, was deeply embroiled in the consequences of the Prime Minister's now-revealed personal behaviour during lockdown and behind the opposition Labour Party by 16% in some opinion polls. The Prime Minister therefore sought to curry favour with both the electorate and his own parliamentary party.

This time, there was not even a pretence that the decision—to end all restrictions including the requirement to isolate—was based upon public health advice shared via the Chief Medical Officers of the UK's four countries: Johnson did not even consult the devolved governments in the rest of the UK before making the announcement. It was the UK's misfortune to have the worst type of government for a public health crisis during the pandemic.

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CHAPTER 10

The Reckoning

A Compromised Scientific Establishment?

Throughout two years of the pandemic, the Chief Medical Adviser Chris Whitty and Chief Scientist Sir Patrick Vallance were Johnson's human shield, even if not always by design. One small but significant example gives the flavour, drawn from one of the many occasions which highlighted the key advisors' compromised role at the 5 p.m. Downing Street Briefings which were orchestrated throughout.

On 23rd March to mark the anniversary of the announcement of the first lockdown, in response to a question as to whether Covid could be eradicated, Whitty answered that smallpox was the only disease ever eradicated by humans; Vallance added that the chances of zero Covid were 'close to zero'. These answers were true but immaterial: they were not the point of the question, as surely the duumvirate must have known. The point was whether the ambition was to drive Covid to the margins, define—and justify analytically—a 'tolerable' level, or simply 'run it hot'. Was Whitty unaware of just how out of step he was with mainstream European scientific opinion, which argues for minimisation, not marginal mitigation, of Covid in Europe? (Priesemann et al., 2021).

The irony is that, to anti-lockdowners, Professor Whitty and Sir Patrick Vallance became suspect symbols of a draconian attempt to drive Covid to the margins. If only this had actually been the case, things might have turned out better. But it was Whitty, apparently influenced by the

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Chief Executive of the Behavioural Insights Team (formerly known as the 'Prime Minister's Nudge Unit when set up by David Cameron), David Halpern, who had been nervous of the British public's willingness to lockdown for long. This judgement was suspect, and moreover was surely not within the Chief Medical Advisor's professional expertise—an irony, given that Whitty repeatedly reiterated his need not to exceed his remit.

As a result of this fateful assumption, Whitty advocated delaying a lockdown until the right moment. On 9 March 2020, he had said, 'There is a risk that, if we go too early, people will understandably get fatigued and it will be difficult to sustain this over time'. This stance was also advocated, confidently and without any hint of doubt, by Whitty's Deputy, Jenny Harries, in her infamous 'fireside chat video' with the Prime Minister (Facebook, 2020). It is still not clear whether 'waiting for the right moment' became a mantra because of a fear of public hostility to lockdown or as the result of a belief that 'flattening the curve' of infection (taken from the influenza playbook) meant waiting rather than 'going hard and early'. More likely it was a bit of both.

As it was, the House of Commons Health and Science and Technology Committees' Joint Report (2021) in October noted that a 'potential reason for the late lockdown was the behavioural advice that was being tendered to the government, for example by the SPI-B committee (the Scientific Pandemic Insights Group on Behaviours)'.

While this committee report made some clear criticisms of the government's failure, it also provided an escape clause. It was implied that the influenza playbook was the only one available, quoting the fact that previous exercises, Cygnus in 2016 and Winter Willow in 2007, 'did not squarely address a disease with the characteristics of Covid-19'. Yet 'there were at least seven other pandemic exercises, including Exercise Alice in 2016, which looked precisely at how the UK should respond to the deadly coronavirus causing Middle East Respiratory Syndrome (MERS-CoV)' (MD, 2021). Jeremy Hunt, co-author of the Joint Report as Chair of the Health Committee, had been Health Secretary from 2012 to 2018. Dr. Phil Hammond, Private Eye's 'MD' columnist, also pointed out that 'these seven pandemic reports would have remained entirely secret until the public inquiry were it not for a Freedom of Information report….' (MD, 2021).

Waiting for the disease to spread so that intervention (via limited restrictions or full lockdown) could have an impact at a time when infection was peaking and ready to decline was incoherent. It was based on an

assumption either that Covid was like flu or that herd immunity could be achieved in this way, or, again more likely, both. Those countries which got it right and hit Covid early and hard were operating already on this basis, so one can only assume that either a parochialism or a nationalistic 'exceptionalism' blighted the policy response.

To return to Halpern: his advice early in the pandemic should not make comfortable re-reading for him. The BBC (2021) reported on 11 March 2020 that the government was 'considering a policy of 'cocooning' groups of people who are most vulnerable to coronavirus'. People in care homes and others who are less likely to survive the disease may be kept apart from the wider population until herd immunity has been established. A government adviser said an army of volunteers could be recruited to support those in group isolation. Dr. David Halpern said they could take pressure off care home staff. If the virus spreads as modelling suggests it will, government advisers believe some hard choices will need to be made about how to protect groups that are more vulnerable to the disease—particularly the 500,000 older people in care homes and those with respiratory conditions. Halpern was quoted: 'There's going to be a point, assuming the epidemic flows and grows as it will do, where you want to cocoon, to protect those at-risk groups so they don't catch the disease. By the time they come out of their cocooning, herd immunity has been achieved in the rest of the population'.

Quite apart from Halpern having championed herd immunity, another major flaw in the approach stands out. The idea that insights into how popular behaviour can be influenced by 'nudging' them in the right direction—insights derived from areas of life utterly distinct from, and trivial by comparison with, a global pandemic—should be the basis for policy is a fatal *non-sequitur*. By definition, the Nudge Unit's modelling could not be relevant to a pandemic unless in a context of abject abrogation of political leadership.

Sir Patrick Vallance (2020) denied that his reflections on herd immunity in March reflected a belief that it was the right approach, and also (in reacting to the Joint Committees Report) claimed that he had always advised frankly to 'go early' in tackling the various stages of Covid. Therefore either his advice was ignored by the Prime Minister or he was sanitising his earlier stance. Whitty too was on the wrong track at first, and compounded this with reference to behavioural science concerning the tolerability and therefore the timing of lockdowns. He also seemed to

imply that an evidenced approach required waiting to see (for example) how much Covid had spread.

More than a year and a half later, in late 2021, official scientists were still taking in the government's washing. On 10th October on the BBC's Sunday morning Andrew Marr Show, UK Health Security Agency Head Jenny Harries denied that the prevailing number of UK deaths from Covid was 'acceptable' but went on to state (of deaths) that '…perhaps Covid is not the most significant element and many of those individuals affected will of course have other (sic) comorbidities which will make them vulnerable to serious illness for other reasons as well'. What was she saying? A Covid death is not really a Covid death? She went on to identify, rightly, that immunity might be waning in older individuals (hence the booster programme) but also slipped in that another explanation might be 'slightly different effectiveness in different vaccinations that have been provided'. This seemed to be code for the AstraZeneca vaccine not being as effective as Pfizer and Moderna (see above), despite previous blanking of any such suggestion in official circles.

Harries also mentioned, rightly, that the Delta variant seemed for now to have eradicated all other variants, but did not emphasise that a higher hospital admission or emergency care attendance risk existed for patients infected with the Delta variant of Covid-19 compared with the alpha variant; indeed, that patients who got sick were twice as likely to need hospitalisation. (Twohig et al., 2021). In this context, and in the absence of any comment from key scientific advisers on how the government had (mis) handled the Delta variant, one wonders if the initial self-censorship at the outset of the pandemic by 'official science', which eschewed the recommendation of border controls, was repeated.

After all, awareness of the risk of Delta significantly predated the UK placing India on the red list of countries (from which travel to the UK was not permitted unless under specific circumstances). Even after India was to be added to the red list, the delay in the date of implementation was fateful, as thousands of travellers from India to the UK entered the country *between* the decision to add India and its implementation. Politicians bear the ultimate responsibility. But once again, the failure of scientific advisers either to make tough recommendations or to define for themselves a red line beyond which repeated rejection of their recommendations would result in resignation on principle, is likely to have worsened the UK's plight.

At the time of writing, the Public Inquiry promised into the government's handling of Covid-19 had not begun, although a Chair was announced on 15 December, 2021 (Dame Heather Hallett). Perhaps more significantly, however, the pertinent facts are already known to any assiduous or even competent, conscientious person. The relative blame to be attributed to politicians (who decide) and scientific advisers (who advise) is arguably a moot point, but even here the truth is known: the scientists got it wrong in the first phase of the new threat from January to March 2020; and the government, reflecting the approach of the Prime Minister, were more than willing to endorse an approach which bolstered their initial 'laisser faire' approach to the threat. How much scientists spoke up fearlessly in private may or may not be unpicked by a Public Inquiry.

The British Press and Other Media

What exacerbated a symbiotic relationship, and vicious spiral, between a reckless government and a fatalistic citizenry, with official scientists seemingly caught in no man's land, was the baleful influence of about two-thirds of the press. The *Mail* group exhibited arguably selective reporting of scientific opinion, with prominence seemingly given to 'Covid mavericks' (Professors Sunetra Gupta and Carl Heneghan were perhaps the two most notable ones in the UK) who were proved wrong in their predictions about the course of Covid, and through its pieces by regular columnist Peter Hitchens, one of whose wild claims led to a correction by the Mail on Sunday, ordered by the Independent Press Standards Organisation (IPSO). Hitchens was known as 'Bonkers' by (among others) Dominic Cummings, Prime Minister Johnson's former chief advisor.

The *Express* and *Sun* mostly took the 'libertarian' line, as did the Daily Telegraph in the so-called 'quality' stable of newspapers (claimed by Johnson to be his 'real boss', again according to Cummings, whose damaging revelations also included quoting Johnson as saying 'let the bodies pile high' rather than have a second lockdown) (*Reuters*, 2021). Other tabloids were also arguing against lockdowns and other necessary measures, with only the *Mirror* standing out from the crowd. Lockdowns are of course a symptom of failure (to keep Covid out of the country, and then to fail to trace cases and their contacts to stop it in its tracks),

but that makes them all the more necessary in the context of a failing, incompetent government.

Over-caution moreover seemed to be mandated from on high within the BBC, with a newly appointed Conservative chairman. Perhaps insecurity over its future funding was complemented by a self-perceived need to reprise the role of 'Auntie' in a national crisis. It was sobering that by far the most accurate reports on the UK's Covid situation came in detail from the New York Times (e.g. Mueller & Bradley, 2020) and from Reuters (e.g. Grey & MacAskill, 2020). Later on, things improved—perhaps as Johnson's reputation fell into disrepute by 2022.

Conservative MPs

Conservative MPs in large numbers were also a source of pressure to avoid lockdowns for too long, and to end them too soon, in particular the 'Covid Recovery Group', with a membership heavily overlapping with the arch-Euro-sceptic 'European Research Group'. Even in February 2021, this group was demanding an exit date for the lockdown which had begun—far too late—only six weeks before. Even Ministers were not immune from pronouncements which would have been comic if not tragic. Grant Shapps, Transport Secretary, for example, claimed on 3 February 2021 that, 'The UK cannot 'close' its border like Australia has because the UK is an island, unlike Australia (03/02/21)'. The Prime Minister, for his part, claimed that Britain could not close its borders because much of its food and medicine came from Europe. One wondered why the people of New Zealand were not starving, by this logic.

The blunt truth is that in a pandemic, a strong government with strong leadership does not appease non-compliant elements of the public or indeed its own backbenchers. This creates a vicious circle of inadequacy. The symbolism was consistently wrong. This continued throughout, from over-optimism clouding serious announcements by Johnson to Conservative MPs crammed together in the green seats of the Commons, shoulder to shoulder, with some standing in huddles at either end of the house—not a mask to be seen. Scientists such as Professor Gabriel Scally, president of epidemiology and public health at the Royal College of Medicine, expressed horror.

The story was consistently one of the government benches, unmasked; opposition benches, masked. This evoked an earlier phase in the USA

when Trump's Republicans politicised mask-wearing. It seemed that the 'freedom-loving' Conservatives sympathised with journalist Peter Hitchens who considered the mask to be a 'face nappy' unworthy of such a proud island race.

The Johnson government buckled easily, and constantly engaged in policy U-turns or reversed decisions in other contexts. Not having a meaningfully independent professional medical and scientific which stood up adequately for the protection and health of the public cost the country dear.

The Joint Committees Report

The Report by the House of Commons Joint Committees (Health, on the one hand, and Science and Technology, on the other), released on 11 October 2021, tried to blame prevailing structures and not individuals, although in referring to 'groupthink' it is clearly a matter for individuals in senior decision-making positions as to whether they have the intellectual *nous* and will to resist this. Seeking to avoid blaming individuals in a Conservative government was hardly surprising, given the fact that both the committees were chaired by Conservatives.

Health was chaired by Jeremy Hunt, who moreover had not taken action as Health Secretary when the Cygnus report drew attention to severe shortcomings in pandemic preparedness, was himself on thin ice, although he confessed that he too had been guilty of groupthink when the Joint Report was launched. Unfortunately he repeated Deputy Chief Medical Officer Jonathan van Tam's football metaphor (of months earlier) that the government's record on Covid mirrored a 'game of two halves'. It was barely appropriate when van Tam used it, and that was before the government repeated its mistakes lock, stock and barrel in failing to restrict the Delta variant, by now complacent with vaccination underway. Now, Hunt merely offended the victims' families, both individually and the Covid Families for Justice.

Science and Technology was chaired by Greg Clarke, a Cabinet Minister in Theresa May's government pre-Johnson, who had no direct reason to be ultra-loyal to the Prime Minister, but he had shown concern about restrictions to curb Covid harming the economy and was unlikely to take no prisoners. Clarke did however draw attention to the 'mistake' in being too timid in confronting the public with lockdown soon enough and politicians.

The Joint Committees Report was a whitewash in some important regards. It excused decisions in the initial weeks of the pandemic in 2020 on the grounds of a 'fog of uncertainty': the government did not know, they say, to what extent Covid had entered and spread, how infectious it was and that it could be transmitted asymptomatically. This was highly misleading. Delay in lockdown long post-dated warnings from Italy's predicament; it was suspected much earlier from Chinese experience that it might be transmitted asymptomatically and this was suspected before Harries, for example, justified the continuation of crowded sporting events. The degree of infectiousness was clearly not known precisely but suspected, again, of being dangerous. In such circumstances, taking major risks was culpably reckless.

Previous policy and previous structural reform had severely weakened the UK's capacity to deal with a pandemic. One should point in particular to: the Lansley reforms and their emasculation and subjugation of national health protection structures, removal of regional testing capacity and diminution of local health capacity and autonomy; the careless subjugation of health capacity generally to the cuts in public expenditure mandated from 2020 onwards, also (like Lansley's reforms) by the Cameron government; and also to the complacent or careless (or both) burying and temporary loss of previous pandemic planning exercises.

But the fact that the Joint Committees report exonerated individuals, by and large, on the basis of structural inheritance and 'groupthink' was neither good enough nor (in the latter case, groupthink) even logical. Previous Health Secretaries like Lansley and Hunt also bore responsibility.

National Audit Office

Meanwhile, the National Audit Office (2021) was another official body to produce a highly critical report on the government's lack of preparedness for a pandemic such as Covid. Many of its observations (for example, about lack of preparedness for the right sort of disease, absence of plans and absence of protective equipment) were by now familiar and more redolent of a failing state than of one of the richest countries in the world. But a revealing additional observation was that the Cabinet Office had allocated 56 of its 94 full-time emergency planning members of staff to prepare for potential disruptions from a no-deal exit from the European

Union, 'limiting its ability' to plan for other crises. It was clear that the issue of Brexit had led to the government either being stretched as to its capacity to tackle emergencies or taking its eye off the ball.

Finally, although not as important as public health, the cost of failure was and is huge. Taxpayers would bear the costs of Covid 'for decades', according to the House of Commons Public Accounts Committee (2021), which went on to state that No 10's response to the crisis exposed UK taxpayers to 'significant financial risks'. The estimated cost of the government's measures had already hit £372 billion in May 2021, and that does not include the 'cost' of death and illness. UK government debt was by then (more than six months before writing) over £2.2 trillion, or about 99.7% of GDP—a rate not seen since the early 1960s. In June alone, debt interest cost £8.7 billion. In one example of future Covid costs, the PAC says taxpayers could be liable for an estimated £26 billion of bad loans. The Committee on Public Accounts (2021) also drew attention to what was already well-known—that 'Test and Trace' had been an extremely expensive failure.

Having ended up in a lose-lose situation (worse outcomes in terms of Covid and public health yet also worse economic outcomes), the Prime Minister and Chancellor of the Exchequer saw no alternative but to lift all serious restrictions on 19 July 2021, despite it being clearly unsafe to do so—in order to minimise *further* costs, such as furlough to businesses and individuals affected by health protection restrictions. In other words, having handled Covid as if there were a trade-off between health and economy, they were then forced into making one, in a self-fulfilling irony.

What made things worse politically, and no doubt reduced compliance from the population with even those sensible, minor restrictions which remained, was more evidence which emerged in December 2021 and January 2022 of government Ministers and staff disobeying their own rules at the height of the previous winter's wave of Covid. Coupled with the Prime Minister's reluctance to endorse fully even those necessary measures which the government took, the mixed messaging and chaos at the heart of government was the recurring theme of what was now nearly two years of Covid in the UK. And now hypocrisy and double standards ('rules for thee but not for me') were added to the charge sheet.

Rationalisation of Failure and Inaction

Some hailed the Omikron variant of Covid-19 as the 'endgame' of the pandemic, admittedly with the word 'hopefully' selectively inserted. With honourable scientific exceptions, it was however the usual suspects who prematurely proclaimed 'peace in our time'. In the UK, we may also note that, in so doing, those who had opposed stringent action to curb Covid often went further—augmenting their earlier hubris with post hoc rationalisation of reckless policy. Let us examine some of the myths which this involves.

- *Omikron's 'uncontrollability' shows that border closures or controls, strict quarantines and tireless tracing and isolation of carriers were always doomed to failure.*

This refrain was heard on the lips of numerous Conservative MPs, right-wing journalists and Republican diehards in the USA, as well as some libertarian commentators in Australia. The latter, as well as being wrong-footed by the prioritisation of public health over 'freedom' by a populist right-wing government, were perhaps also ironically complacent about the Covid threat as a result of that (federal) government's very success achieved through draconian action.

The myth that the latter was unnecessary betrays audacious effrontery, and Australia shows us why. The death rate in Australia over the two years of the pandemic to date has been 1/27th of the UK's. Australia's total deaths to 15 January, 2022, of 2673 mapped onto the UK's population (gauged at two-and-one-half times that of Australia) would produce something close to 6500, whereas the UK has had by this date more than 175,000 deaths with Covid as the cause on the death certificate as reported by the UK's independent Office of National Statistics, as opposed to the 150,000 reported by the government.

Omikron is of course not 'uncontrollable'. But even if it were, avoiding UK-level mortality and morbidity over two years is in itself a major achievement. That is without mentioning severe morbidity and hospitalisation (with concomitant strain on health services *aka* real people working way beyond the call of duty), disability through 'long Covid' and the increased risk of new variants as a result of 'running Covid hot'.

- *The fact that we are living with Covid now (after a fashion) shows that we could always have done this, without serious restrictions.*

This associated myth is also egregious. Post-vaccine death rates and serious cases (especially those requiring intensive care) are drastically reduced from the pre-vaccine situation.

- *It was always necessary to learn to live with Covid.*

It was not always so, had the international community acted collaboratively and speedily, and had nation-states been steadfast with or without such action. But that is not the question, in any case. The question is, *at what level do we have to live with it*. Until we know that it has weakened into what Brazilian President Bolsonaro called (unforgivably, at the outset) 'a little flu', a compassionate public health policy would answer, *at the lowest level possible*. Research quoted above suggests that minimising Covid minimises economic damage—there is not a trade-off between the two, as the UK government persistently assumed.

The UK government often dressed up its short-termist concern with the economy as concern for health. We heard throughout the first two years of Covid that *restrictions damage health, especially mental health but also access to health care for non-Covid patients*. The UK however provided a natural experiment which demonstrated how much the latter part of this claim was the opposite of the truth. 'Opening up' the country (England) prematurely on 19 July 2021 meant that Covid (then the Delta variant) was 'run hot'. As a result, the NHS was pressured all over again, and people could not access services for other morbidities so easily.

Even as regards mental health: the true reckoning is the trade-off between those adversely affected by restrictions such as lockdown and those adversely affected in the *absence* of lockdown and other restrictions *i.e.* those who fear serious illness or death as a result of others' insouciance in the absence of restrictions.

False Comparison

Those opposed to lockdowns and, in some cases, even mild restrictions often make false comparisons, even when these are couched in reasonable form. For example, the Editor of the *Spectator* Fraser Nelson (Telegraph, 2022) suggested that Sweden's eschewal of 'harsh' restrictions had resulted in a lower death rate from Covid than England's. This was a classic case of a bilateral comparison drawing the wrong conclusion. It is furthermore ironical, in this case, to see the Right lionising socially progressive Sweden, for once; doubly ironical, in that the King of Sweden and Prime Minister both apologised at the end of 2020 for Sweden 'getting it wrong'.

Nelson argued that Sweden's death rate in the first wave of Covid was bad (like the UK's) but that subsequently it performed better than the UK in later waves. Yet he does not see that both countries' bad records in 2020 were due to the absence of lockdown (Sweden) and botched, late lockdown (UK). In later Covid waves, the Swedish population behaved cautiously, voluntarily, consensually; with a similar outcome as in countries which were less civic-minded countries but had harder restrictions. In any case by 2021, Sweden had moved away from its stance of minimal restrictions, to a middle way between minimal and hard restrictions. In later Covid waves, it was again *late and inadequate* lockdown in the UK which produced shockingly high death rates.

The defiance of a significant minority in 'freedom-loving' England combined with Boris Johnson's recklessness would have fatally boosted the UK's death rate from Covid, even further, in the absence of lockdown, and the NHS would have collapsed. The language used by the UK government was, 'prevent the NHS from being overwhelmed'. It *was* overwhelmed. But it did not collapse.

Sweden, like Japan (where total deaths up to February 2022 were 20,000), got away with steering a middle course as a result of a more consensually minded and/or compliant population. Even so, its record was worse than its Scandinavian neighbours. The Swedish Chief Epidemiologist Anders Tegnell, at the beginning of the pandemic, had feared wider social damage (*e.g.* undiagnosed cancer, longer hospital waiting-lists and education) through 'untested' lockdowns. But this ignored the risk of damage to all these factors through uncontrolled Covid.

In the UK, access to the NHS suffered much more from high Covid levels than lockdowns (during which the NHS was open), as data since

'Freedom Day' on 19 July 2021 suggest. Even education has arguably suffered more through long periods of 'stop-start' disruption, and high levels of absence of staff and pupils from Covid, rather than from shorter periods of lockdown.

The UK's restrictions, what is more, were not 'harsh' by comparison with those in the countries which succeeded in keeping death rates lowest in the world (Sweden not among them). The reality is that the UK's higher death rate is not *because of* lockdowns—a ludicrous proposition. It is primarily because of how lockdowns and other restrictions were begun too late, enforced poorly with poor follow-up in terms of effective tracking and isolation and ended too soon.

A proper comparison requires a multi-country analysis. The 'anti-restriction' lobby, even in its more literate incarnation, dealt wholly in phoney comparisons, either unaware or uncaring of the serious research done on the topic.

Corporate Manslaughter?

The argument was made that the UK public authorities were guilty of corporate manslaughter under the English statute of 2007, which had been passed overtly to make *inter alia* government departments potentially culpable (or perhaps culpable homicide in Scots law?) For example, Nazir Afzal, former chief crown prosecutor for North West England, said: 'Sending someone into a high-risk situation against one of the most infectious diseases we've come across in 100 years without proper protection needs a proper investigation and may meet the threshold for criminal sanction. In due course there ought to be an investigation by either the HSE or police to identify whether the lack of PPE has caused somebody's death' (*Guardian*, 2020, May 8).

Public authorities are not exempt from duties of care to their employees even when responding to emergencies. A key issue is whether organisational and management failures contributed to those deaths. The issue is arguably not just PPE, but the whole Covid 'strategy' including the de facto decision to sacrifice lives in pursuit of other objectives, leading to delayed or wholly eschewed lockdowns et al. The People's Covid Inquiry, chaired by Mike Mansfield QC on behalf of the Keep Our NHS Public campaign, considered the issue of misconduct in public office. It

held hearings with evidence from public health experts such as Professors Sir Michael Marmot, Gabriel Scally and Sir David King, convenor of Independent SAGE (see for example BMJ Opinion, 2021).

The evidence for misconduct would presumably include: the Prime Minister Johnson recklessly asserted, with no evidence to back up the assertion, that the risk from pandemics was exaggerated (Johnson, 2020; Paton, 2021). He failed to chair the first five COBRA (Cabinet Office Briefing) meetings on the pandemic. The government failed to implement border controls and/or effective quarantine or travellers. The government took the risk that asymptomatic transmission of Covid would not happen, despite WHO having already claimed this was possible before it was known to be the case. The Health Secretary agreed to the suspension of community testing far too readily without questioning how extra testing might be mobilised to overcome a shortage of capacity. The Prime Minister was culpably dilatory in arranging the first 'lockdown', which in turn was ended too soon, with some of the restrictions lifted without the criteria in the government's own 'traffic-light' system being met.

Subsequently, rising Covid numbers were ignored for too long at the end of the summer, and the time for a second lockdown should have been early September. But Johnson repeated history in delaying the second lockdown, and went on to do the same with the third, having U-turned overseen chaos over an aborted Christmas relaxation of restrictions and a 'closed-open-closed' confusion over schools. Next, the Delta variant was mishandled; and yet restrictions were ended as if it did not exist (Kluge, 2021; Twohig et al., 2021). Whatever the debate around the milder yet easily transmissible Omikron variant later still, the damage had long since been done. And with Omikron, England was an outlier even within the UK (and also Europe) in ending even minor restrictions such as mandatory masks indoors and distancing, which could have at the very least reassured its more vulnerable, risk-averse and nervous citizens.

Judges tend to argue that governments as a whole (as opposed to individual decisions within departments by managers and officials) should be judged at the ballot box rather than in court. It was unlikely that broad-based corporate manslaughter charges would stick. One might reasonably argue however that, if corporate manslaughter is only applicable to 'small' cases, then the 2008 Act making it applicable to government departments is not working as it should or could.

One might also argue that the ballot box at a general election is a haphazard device for punishing a government for mismanagement on one

issue, however cataclysmic. That said, the irony that it was not the overall record of carnage through Covid policy, but the Prime Minister's brazen disregard of his own rules which brought his popularity crashing down, might nevertheless be considered an ironical surrogate for justice.

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PART IV

How Much Pressure Can the NHS Take?

CHAPTER 11

Toxic Cocktail: A Hangover from Austerity, the Pandemic, Brexit and Barely Sorted Social Care

The Legacy of 'Austerity' and the Pandemic

By the 2020s, not only was austerity in play, but the consequences of the pandemic, Brexit and the running sore of social care were also making their mark. For the NHS, then, reversing unhelpful reform had been the bare minimum for survival in a hostile climate. But events ensured it would be nothing more than that—*necessary but not sufficient* for the future of the NHS.

In 2022, the task confronting government was a basic one but a—to keep the NHS from imploding. Even with significant extra money beyond the £12 billion promised for (both) health and social care by the government on 7 September 2021, the workforce challenge was immense. To give but one example: the following month, it was revealed that one in five nursing posts in the NHS were unfilled. Building back after the pandemic would require more than a slightly larger than usual wage settlement. And that is not even to consider the pandemic's long-term effect on demand and need for care as a result of 'long Covid', as well as its more direct effect on supply of labour and the adequacy of resources.

The repeated subjection of the NHS workforce to the consequences of the pandemic UK-style left scars of short-term exhaustion but also a whiff of undervalued staff. The derisory offer of a 1% wage rise for nurses in England in March 2021 was reversed and replaced in July with an offer of 3%, but the damage was done in terms of revealing

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the government's instincts (as with the row over its initial failure to fund free school meals during vacations for children of key workers during the pandemic—another of the many U-turns). Even one of the Prime Minister's own nurses during his hospitalisation with Covid had left the service in frustration—one of many.

The need to invest in staff on a huge scale was made more acute, but also more difficult, by Brexit: many European workers returned home and recruitment from Europe was in turn more difficult. Additionally the NHS faced a mounting beds crisis as care homes suffered from unprecedented and increasing staff shortages, and were forced to stop taking patients from hospitals. What is more, it was necessary to free up space in the (English) NHS to tackle a backlog of 6 million people (and rising), equivalent to almost 10% of the population) awaiting treatment. In February 2022, the Department of Health's plan to tackle the backlog was delayed amidst rumours of a row with the Treasury over inadequate targets, only to be considered inadequate when announced. The other UK countries faced similar multi-faceted pressures, with (for example) the Scottish ambulance service in serious crisis towards the end of 2021.

Efforts to speed up the discharge of hospital patients into the community were hampered by care worker shortages. Britain's largest not-for-profit care home provider, MHA, had already had to close one in ten of its homes to admissions from hospitals (Guardian, 2021). Care homes in England faced the biggest staff shortage on record at the end of summer 2021, with 105,000 positions unfilled (Skills for Care, 2021).

Brexit, Trade Agreements and Uncertainty

The impact of EU competition and procurement laws on the NHS had been a contentious issue for some time. A combination of the Competition Act, provider licences and regulations continued in theory to prohibit anti-competitive behaviour by NHS providers and commissioners. This was because EU directives were incorporated into UK law, meaning the UK government would need to repeal or amend UK law if it wished to change current competition policy.

The applicability of EU law to the UK, and its possible constraints upon UK policy—for example to prevent the reversal of market reforms even if desired by the UK (English) government—had never really been tested, as no firm denied a contract appealed to the EU and therefore

teased out a more detailed statement of the EU's position from the European Court of Justice. What is more, it was British law since 1990, and especially the 2012 Act, which seemed more seminal in enforcing market procurement for NHS services.

This was in England only. The EU's competition remit did not even potentially apply to Scotland and Wales, as their rejection of the market in various stages, post-devolution in 1998, made their NHS services unequivocally public services outside the remit of the EU Competition Act.

More worrying for the future, *post*-Brexit, was the scope of any future Trade Agreement with the USA, and/or the UK's involvement in a Pacific Partnership agreement. Just as the proposed Transatlantic Trade and Investment Partnership (TTIP) between the EU (of which the UK was then a member) and the USA being negotiated between 2013 and 2016 had given rise to legitimate worries about the NHS being penetrated and/or sued by corporate interests, any post-Brexit deals could raise similar worries.

TTIP was never concluded and was formally logged as obsolete by the EU in 2019. But the future was unclear, despite the clamour from all mainstream UK politicians that 'the NHS is not for sale'. No-one noticeable—other than perhaps the then-Labour leader Jeremy Corbyn in election debates in2019—was suggesting that the NHS *in toto* could be for sale. But a trade deal could well affect the rights of corporate interests (from the USA and elsewhere) to tender for, and supply, clinical services—even if the UK's own laws removed such rights domestically (as with the HCB of 2021, repealing Section 75 of the 2012 Act) (Dayan & McCarey, 2021)

Returning to the EU and Brexit, there were no immediate changes when the transition period of Brexit ended. However after December 2020 (the end of the transition period of one year following Brexit on 1 January 2020), there was and is divergence between the EU's competition law and the legal framework underlying the UK's Competition and Markets Authority. It was and is a complicated area, and a legal minefield, in that some issues are covered by the Withdrawal Agreement and some are not. If the latter, then whether or not UK law needs to be amended or not then becomes a moot point.

On 24 December 2020, the EU and the UK reached a Trade and Cooperation Agreement (TCA), which sought to provide a 'level playing field' in the way that UK and EU businesses were regulated. The TCA

included a commitment by the UK and the EU to maintain effective competition law and to ensure its enforcement by independent authorities. The TCA also emphasised the importance of cooperation with regard to developments in competition policy and enforcement activities (Morgan Lewis, 2021).

The direction of the English NHS after 2015—integration and collaboration; removing the legal requirement of competitive procurement—and the fact that the other UK countries had not had an 'NHS market' since 1998 meant that, after Brexit especially, neither the EU nor the Brexit agreement (after the one-year transition period following the UK's formal exit from the EU) seemed to affect the NHS. But this did not mean that future bilateral deals between the UK and other countries, now allowed post-Brexit, would not affect the NHS. Even if such deals removed integrated public services from the threat of being 'opened up' to corporate interests, the reintegration of the NHS in England was not as unequivocally 'pro public' as elsewhere in the UK. Therefore the issue was likely to be moot for years to come.

Another issue might be relevant—retained EU law and related issues. As Mayer Brown (2021), explained, from 2018 to 2020 the UK government made more than 600 pieces of domestic secondary legislation, making around 80,000 amendments to retained EU law. For the most part, these were technical, to ensure that the retained EU law would be clear and operable when applied purely in a UK domestic context. However, there were also substantive changes, and some pieces of EU legislation were revoked entirely. So it is important, at any point in time, to check an up-to-date version of retained EU law taking account of any amendments made after Brexit in the UK.

Any post-Brexit amendments made by the EU to its legislation after 31 December 2020 were not incorporated into UK law. Therefore, while most retained EU law in the UK may initially be close or even identical to the EU's own 'classic' EU law, the two will inevitably diverge over time as they evolve independently of one another, except in those areas where the UK-EU Brexit deal restricts divergence.

Retained EU law is essentially a snapshot of EU law as it applied in the UK on 31 December 2020, which had been 'cut and pasted' into our domestic legal system. Sections 2–4 of the Withdrawal Agreement established three categories of retained EU law—domestic law which implemented or related to former EU obligations, e.g. the UK's Working Time Regulations, central to the NHS; EU legislation which was directly

applicable in the UK without implementing legislation, e.g. on data protection, also central to the NHS; and other rights in EU law that had direct effect in the UK. This amounted to 150,000 pieces of EU legislation, although only around 3000 of them have a practical impact in the UK. (Mayer Brown, 2021).

Relative powers *within* the UK, in terms of Westminster's relationship with the devolved nations, are possibly affected by Brexit. As Dayan et al. (2020) pointed out: officials in Scotland, Wales and Northern Ireland were concerned about their ability to regulate in the future to improve public health, tying them to unclear Westminster plans, and depriving the UK of the opportunity to learn from regulatory experimentation, such as Scottish measures on smoking in public places and alcohol pricing. The Internal Market Act, approved on 17 December, partly addressed these fears, by including amendments which permitted regulatory divergence from UK-wide rules (where the four constituent governments had agreed on a common approach). But the fear that Brexit would actually reduce flexibility in the three smaller countries and territories of the UK was not put to bed.

As well as the above regulatory issues, Brexit was directly contributory to the pressure facing the NHS. Leaving the EU's single market meant that there was no longer free movement of labour between the UK and European Economic Area (EEA) countries. In 2020, 13.1% of staff working in the NHS had a non-British nationality: 5.6% were from EEA countries and 7.5% were from non-EEA countries. In adult social care 16% of the workforce was non-British: 7% were from EEA countries and 9% were from non-EEA countries. Under a new rule recommended by the Government's Migration Advisory Committee, carers would be considered 'low skilled EU workers' and would not get preferential access to the UK labour market after the UK left the EU (Age UK, 2020). Social care exhibits very high staff turnover, which reached 30.4% in 2019/2020, equating to 430,000 people leaving their jobs.

The social care workforce gap produced by Brexit has been estimated to range from 350,000 people in the most favourable scenario, to 1.1 million people in the worst-case scenario by 2037, depending on levels of migration from the EU (Miele, 2021). This will likely depend on the new regulations around EU migration. From January 2021, thresholds currently in place for skilled migrants were replaced by a points-based immigration system, equally applicable to EU and non-EU migrants. New skilled migrants had to have a job offer in a skilled profession, with a

minimum salary of £25,600. For jobs in the shortage occupation list, the salary threshold was to be £20,480.

In March, senior care workers and managers were added to the shortage list by the UK Home Office, but it was likely that this would not be enough. Although the government launched a Health and Care Visa, a fast-track visa route for those taking 'skilled' jobs such as senior care workers, care workers were not initially categorised as a shortage occupation and in any case had an average annual salary of £19,000, below the threshold even for the shortage list had they made it onto that list.

Social Care

Before reform, if an individual was assessed as needing care in a care home, they would have to pay for it themselves if they have assets worth more than £23,250 (including their home.) If they were assessed as needing care in their own home, the £23,250 threshold still applied but the value of their home was no longer taken into account. If they had assets below £23,250 but above £14,250 they would be charged a proportion of the costs of their care.

Furthermore, people may also have to contribute to their care from any income they have: if someone was in a care home, they may contribute all their income, apart from £24.90 a week for expenses. If someone received care at home, they might have to contribute all their income, apart from a sum no higher than the Minimum Income Guarantee, which varied according to age and other circumstances.

If people were not eligible for publicly funded care, there was no limit on how much they might have to pay privately.

If an individual had assets above the £23,250 threshold, they had to pay for their care, rely on family or friends, or go without care. If people did pay for themselves, there was no limit to how much they might have to pay over their remaining lifetime. The average cost of a care home in England is around £35,000 a year and some people spend many years in care. So, it was quite possible to end up paying 'catastrophic costs' of £100,000 or more. The Dilnot Commission (2011) had estimated that 1 in 10 people might pay more than £100,000.

Reform of Social Care

The proposals of 2021 set a 'cap' on the amount an individual could pay for care in their lifetime. If someone had to contribute towards the costs of their care, there would now be a cap on how much they are expected to pay over their lifetime. This cap was to be set at £86,000. Once an individual had spent that amount, the government would take over paying their care costs. All people with assets worth less than £20,000 would have their care fully covered by the state, and those who have between £20,000 and £100,000 in assets would see their care costs subsidised on a sliding scale, with diminishing subsidies the greater one's assets. However the devil was in the detail here, as we will see below.

The cap would however only cover the cost of a care home allowed by the individual's local authority or the number of hours of care at home which the local authority considered an individual to need, at a locally capped price. Significantly, the cap would not cover the substantial cost-of-living expenses in a care home, i.e. accommodation and meals.

The government promised £5.4 billion over three years to cover implementing the cap, floor and improving existing services. It also promised that it would better support unpaid carers, provide more housing adaptations to help people live at home, and more staff support. But it also said that it expected local authorities to meet rising demand and costs of the existing system through 'council tax, the social care precept, and long-term efficiencies'. Additionally, a new health and social care tax was announced on 7 September 2021 to pay for reforms to the care sector and NHS funding in England. It was designed to raise £12 billion a year, designed to tackle the health backlog caused by the Covid pandemic and to bolster social care.

The tax was to begin as a 1.25 percentage point rise in National Insurance from April 2022, paid by both employers and workers, then to become a separate tax on earned income from 2023, calculated in the same way as National Insurance, to be paid by all working adults and legally ring-fenced to go only towards health and social care costs. Income from share dividends would also see a 1.25% tax rate increase. Scotland, Wales and Northern Ireland were to receive an additional £2.2 billion to spend on their services, but the UK tax was for English health and social care. £5.4 billion over three years from 2022 to 2024 was to go towards changes to the social care system.

Devil in the Detail

A political row developed over the government's later guidelines, published on Wednesday 17 November 2021 that part of the care cost of lower-income individuals which was paid publicly by local authorities would not count towards their maximum ceiling of £86,000 of personal liability for costs. That made the policy more regressive, as it made it harder and longer for a lower-income individual to reach the point of not being liable for care costs. Added to the fact that a ceiling of £86,000 could comprise all the assets of a less well-off individual or family, this meant that the policy would not rescue the 'nearly poor' for what, for them, would be catastrophic costs. It also robbed the policy of any chance of getting cross-party support, as well as causing unease on the Conservative back benches, especially among the so-called 'Red Wall' Tory MPs who had won their seats in what had until 2019 (or in some cases 2017) been safe Labour seats.

Labour attacked the proposal. Then-Shadow Health Secretary Jon Ashworth told the BBC on November 17, 2021: 'They don't protect everybody from catastrophic costs. It is actually a care con because if you need social care and you are fortunate enough to earn a £1m house, say in the home counties, then 90% of your assets will be protected. But if you are unfortunate enough to need social care and you live in a £80,000 house in say Barrow or Hartlepool or Mansfield, you'll lose nearly everything. That is manifestly unfair. That is not levelling up, it is frankly daylight robbery'.

The architect of the 2014 law to reform social care which had never been implemented, Sir Andrew Dilnot, who had originally welcomed the social care proposal as a step forward, was 'very disappointed' by these latest guidelines. He told the House of Commons Treasury Committee on March 18th that, '… the less well off will not gain any benefit from the cap' and went on to describe the savings of £900 million estimated by the Treasury that, 'these are small amounts of money compared to overall public spending and very small amounts of money compared to what is being raised to pay for health and social care'.

There was a recurring tendency for the Johnson government to snatch defeat out of the jaws of a potential victory, even when it took a bold initiative. Behind the scenes, there was tension between the two most important members of the government—the Prime Minister and the Chancellor of the Exchequer. Boris Johnson had little interest in

economic doctrine, and loved the popular grand gesture, whereas Rishi Sunak, the Chancellor, was a Thatcherite doing his sums.

A means of both limiting the potential 'catastrophic' cost of social care for anyone (i.e. instituting the 'ceiling' of liability for cost) and yet also ensuring that this ceiling was not a major proportion of the cost of one's property for less well-off people, was to institute a higher 'floor'. The threshold of wealth or income at which people became liable for the cost of care (as opposed to it being paid from the public purse) would be raised significantly and the 'taper' or sliding scale by which subsidy was reduced would correspondingly reach higher still.

This would be much more expensive for the public purse, and would only be fundable through higher tax for those richer citizens whose care costs only represented a small percentage of the value of their property. This was never going to be a runner for a Conservative government. Another option was to have mandatory insurance, whether wholly public or a private/public mix, to cover costs of social care for all—a 'national care service' or 'national care insurance'. Neither was this a runner. So the government was left with a patch-up solution—better than before, but a long way to go if the problem were to be tackled comprehensively.

Cheese-paring by the Chancellor had been a problem before, during the Covid pandemic on more than one occasion. For example, better compensation for poorer people who were required to isolate (with Covid or after exposure to Covid) would have helped mitigate the spread of the virus. Now, with social care, we saw a similar phenomenon—cheese-paring snatching defeat out of the jaws of victory. It possibly illustrated, as with Covid, the inability or unwillingness of the Prime Minister either to master the detail in time, or to show strong and stable leadership, enforcing his will when the Chancellor pared away at an important policy initiative. As 2022 began, the Prime Minister was weaker than ever, seeking to please whomsoever in an attempt to shore up his position.

There was of course no easy answer to the social care problem. One solution in theory was to unify NHS and social care budgets, and manage the transition between the two for patients more directly. But quite apart from the logistical difficulty of merging budgets for the NHS (which was mostly free at the point of use) and social care (which was means-tested), either healthcare or social care was likely to feel the pinch in a unification. In past performance, it would be social care: hospitals in trouble are more of an acute problem (no pun intended).

Yet even with separate and fully ring-fenced budgets, at the other extreme, the pressure on the public purse would continue to be intense. An example of the unprecedented pressure on the NHS hit the headlines on 11 November 2021, following a BBC investigation. Lives were at risk because patients faced unacceptably long waits for a 999 response. Average waits for emergency callouts for problems such as heart attacks and strokes were taking nearly three times as long as they should in England. Targets were being missed in the rest of the UK too, with some seriously ill waiting up to nine hours for an ambulance. There were both long waits for crews to reach patients and also delays when ambulances arrived at A&E but had to spend hours queuing outside, because the hospital was too overcrowded to accept the patient. Part of the overcrowding was due to delayed discharges of patients for whom the transition to a nursing home, residential home or other location was problematic for either financial or other more personal reasons.

An effective social care reform might in theory help, by diminishing delayed discharges from hospital to care homes. But the government's puzzling abolition of the delayed discharge regime (under which local councils were supposed to pay fines to hospitals for delayed discharges from the NHS to local government-controlled social care) could actually make things worse. It was claimed to do the opposite, but it was not clear how.

The Pandemic on Top of Austerity

Even more worrying for the medium term was the relative failure of the UK to recover as well or as quickly from Covid as comparable countries. On 11 November 2021, it was revealed that the UK's GDP was still 2.1% below pre-pandemic levels, the worst performer in the OECD: for example, the USA was now 1.4% above its pre-Covid level and France was at that level (or rather only 0.1 of 1% below it). This did not bode well for the future capacity of public spending in general and expenditure on the NHS (and social care) in particular. At the beginning of February 2022, the UK's growth forecast for the UK was reduced in the context of the prevalence of the Omikron variant of Covid. Supply-chain problems, the price of energy and other factors were international, if not global, but they tipped the balance towards crisis more readily weaker economies. Add to this that the independent Office for Budgetary Responsibility—separating the effects of Brexit and the pandemic on trade in its analysis—calculated

that Brexit had reduced both imports from, and exports to, the EU by 15%.

As regards the 'hit' from Covid itself, the UK government pleaded mitigation in that it had been worse hit by Covid than many others (not the story it told when discussing its Covid record, funnily enough). But this was in any case a duplicitous logic, which said in effect, 'our policy worsened Covid, which in turn hit the economy harder. But we are now going to *use* our worse Covid situation shamelessly to explain away poor economic data'.

Between 2010 and 2019 the annual rises in spending on health were well below those traditionally given since the birth of the NHS. Between 1948 and 1979, under both Labour and Conservative governments, the average annual increase in NHS expenditure was c.3.5% above inflation. From 1979 to 1997 under Conservative governments, it was a little less, at c.3.25%. Between 1997 and 2010, under Labour, it averaged 6%. Between 2010 and 2015 (after the fiscal crisis induced by the international banking crash of 2008–2009) under the Conservative-Liberal Democrat Coalition government, it was 1% (which represented a cut in real terms once one adds in the fact that inflation among NHS inputs was higher than that in the economy as a whole). Between 2015 and 2019, it was c.1.6%. Since 2021 it was estimated to be approaching 4% again. But this would not be nearly enough. As pointed out in Part III, the UK was threadbare in clinical staff.

Post-Covid, huge stresses developed upon the NHS, as quoted above: these not only lengthened waiting times hugely for elective surgery, but also in terms of waiting times for ambulances and for treatment in, or via, Accident and Emergency. The NHS had been barely coping pre-Covid: all the advances of the Blair and Brown years in terms of extra resources had been reversed and more. So the challenge post-Covid was not just a short-term one. None of this boded well for an NHS requiring much more money to live up to the expectations of the better-off majority, as discussed in the next chapter.

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CHAPTER 12

Real Reform?

Some NHS Sacred Cows

Notwithstanding the immediate pressures of survival, we may still wish to envisage an NHS which meets the requirements of individuals for timely and high-quality care in such a manner that private payment for health care was seen as redundant by a critical majority of the population. That incidentally was the vision for public services of Tony Crosland in 1956, the post-war socialist moderniser whose classic book was reissued in 2006 on its fiftieth anniversary with a foreword by Gordon Brown (Crosland, 2006). That vision also motivated the Labour governments of 1997–2010 at their best; but policy and (especially) its implementation did not begin to live up to the vision.

As Tony Blair knew instinctively, creating responsive healthcare systems in the countries of the UK involves slaughtering some NHS sacred cows. Those who are sceptical of the NHS's merit often point to the fact that it is the nearest thing the UK has to a civil religion, which it is sacrilege to criticise in any fundamental way. Yet defenders of the NHS, such as myself, also need to see the downside of this belief in the NHS irrespective of its performance. It infantilises the political debate. So, what are the sacred cows which need to be slaughtered?

Firstly, the GP as gatekeeper: it is claimed that the system of universal registration with a GP, which is then the gatekeeper to specialised care, is the jewel in the NHS's crown. This is close to the opposite of the

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truth in modern times. The inability to access specialist outpatient care without referral means that the UK NHSs are more bureaucratic than some Scandinavian equivalents and also social insurance systems such as France's—and allow less flexibility for patients. If one manages to get past the GP to see a consultant and then is subsequently discharged, one is back to square one.

It would make sense to organise GPs and specialists in outpatient clinics—call them polyclinics if you must, despite perhaps misleading historical parallels from other countries. Then appointments could be tailored as appropriate. The specialists would be part-time in the polyclinic as well as working in hospitals with inpatients.

This would allow a patient to 'stay with' a specialist without going back to square one after an episode had been closed. It would also necessitate the end to the role of the GP as linchpin commissioner as well as gate-keeping referrer. It is not 'politically correct' to say so: but so far, so good. The reforms from 1990 to 2015 cost billions and achieved little: increasingly they featured the GP as budget-holding commissioner, to little effect other than creating an opportunity cost in terms of direct patient care.

The new Integrated Care Systems (ICSs) would not, it seemed, have the GP as the organisational linchpin of the system. This was regretted by some but to me was welcome *if* it meant that GPs would have the right to be patient advocates rather than budget-holders. The danger was that it ushered in the risk of even more restrictions on direct access to specialised care. The jury is out on whether the long-term trend will therefore be to private non-urgent care for all but the poor as 'consumers' vote with their feet to leave the NHS.

The UK is in danger of importing the worst aspect of US health care. I do not refer to an alleged 'privatisation', but to the phenomenon that those who rely on publicly paid care have to wait until their conditions worsen and Accident and Emergency becomes the only 'immediate' port of call. Telling patients to use the GP instead is doomed to fail. It always has. Often what is required is quick specialist investigation and diagnosis, then treatment as urgently as necessary.

The UK GP practice does not currently provide comprehensive primary care. It provides *uber*-short appointments and often failure to diagnose, hence the A and E dilemma. This is not about criticising individual GPs or practices, although some deserve criticism. It is because of the pressure upon a poorly structured system.

That said, there is a cultural problem in much general practice, which is being tackled too slowly, and not at all in some locations. This has remained at 'street level' irrespective of decades of system reform. Battling to get a blood test, for example, often means that only those well-informed people with sharp elbows can do better within the system. Decades of 'GP-led' reform have not changed this: it is the systemic, unchanging reality below the thin veneer of snazzy reform in jazzy language, despite the best efforts of the best GPs to change this state-of-affairs.

Foreign visitors—not just from the USA, France or Sweden (private, social insurance and NHS systems, respectively) but from former-Soviet Poland—often are bemused by the inability to see a specialist and get timely treatment. The NHS prides itself on not ordering 'unnecessary' tests or paying for drugs of alleged low cost-effectiveness, but this language often conceals a reality of illnesses missed and conditions inadequately treated, with (too often) grievous results.

Next, those with complex, borderline, changing, or multiple conditions often require a complex or difficult-to-determine journey through and across the healthcare system. The NHS is particularly bad at this. Often each specialist silo or segment is of the highest quality. But the patient lacks a coordinator to guide him through it and get the right diagnosis and treatment at the right time. That coordinator is not, and cannot be, the GP. The latter is both drastically too busy and too generalist. It needs to be either a lead specialist/physician or a clinically aware non-medical clinical manager who can be the patient's advocate.

While many of the pilot projects for 'integration' from 2015 to date have talked the talk of the patient advocate/coordinator, this has been at the level of systems, if at all, not at the level of the individual patient. The Multi-specialty Community Providers (MCPs) and integrated Primary and Acute Care systems (PACs), for example (see above) do not necessarily help with the sort of situation where—for example—a patient in hospital with Covid whose cardiac pacemaker has to be removed is told he has to go back to the GP to be referred to have it re-installed (Personal communication). Atypical this may be: but there are other nonsenses, based on rigid working patterns and truculent local cultures, for which 'integration' projects do nothing per se.

In the UK, private outpatient care, with or without insurance, offers the kind of flexibility which ought to be available within the NHS. The Blair government sensed the cultural—and financial—problem correctly,

but lost the plot in its reform agenda. The latter became 'more market', coupled with a patient choice agenda which gave a tick-box choice of hospital via 'Choose and Book' (later to become the NHS e-Referral service) but *not* a choice of specialist.

One option is to remove the distinction between private and public GPs and hospital doctors in the remuneration system. All GPs charge a set fee for each procedure or consultation. All hospital doctors are employed sessionally. Then the transparency of any public–private conflict of interest ('I can see you next week in my private clinic') would be exposed, ideally. But more importantly, the public system would pay properly for what was required, and where it was required e.g. Consultant sessions in polyclinics. Salaried doctors are a good idea when the aim is to reduce usage and costs. But if the problem is under-supply, then a different reimbursement system may have advantages, with safeguards and regulation of charges. Yet this scenario would be expensive; probably unaffordable.

More generally, the worry is that there will not be enough money quickly enough, if ever, to make NHS care truly responsive. Those who want (for example) timely reassurance about skin moles from a dermatologist would have to go private (increasingly the case, after the brief interregnum of the latter Blair/early Brown years of plenty). Social insurance in France and Sweden's NHS both allow direct access to specialists.

In this connection, it is worth noting that one important conclusion of the comparison of the English NHS with California's Kaiser Permanente (Feachem et al., 2002) twenty years ago (which raised some key issues despite some methodological controversies) was not only ignored by the government of the time which was allegedly learning from Kaiser, but turned on its head. Kaiser's significantly greater number of senior hospital specialists per weighted population than the NHS allowed more effective and active management of patients which allowed shorter lengths-of-stay without safety suffering, but this insight was lost on an NHS which was too busy deepening a purchaser/provider split which ended up robbing hospitals of funds without improving primary care.

In England, however, the rhetoric of the time, especially from Health Secretary Patricia Hewitt (2005–2007), was more about challenging the numbers of hospital specialists in order to spend more in the community. Centrally mandated 'quality' initiatives such as Lord Ara Darzi's (2008) could not address such aspirations, as their remit did not challenge the constraints or assumptions of such policy.

In England, the market-oriented purchaser/provider split had meant, by 2007, that far too many small 'commissioners' had gone off at their own tangent, in an uncoordinated way. In the meantime, their profligacy on local schemes which were not coordinated regionally led to hospitals being starved of funds even at a time of expanding NHS budgets. In a nutshell, local 'commissioners' tried to spend the money themselves rather than resource hospitals properly. So we had the bizarre spectacle of more money than ever before for the English NHS yet more acute hospitals in deficit than ever before.

Frustratingly, while the Blair/Brown governments genuinely improved access to a better-funded NHS, they could have done so much more if they had not wasted billions on such a poorly conceived and even more-poorly implemented reform programme.

In 1991–1992, I was involved in advising the Shadow Health Secretary, Robin Cook, in how to respond to the internal market, and develop Labour's policy for the general election in 1992. I advised against endorsing the incipient purchaser/provider split. This was perfectly practical at that time, for the Conservative government had decided that, in the run-up to the 1992 general election, damaging headlines should be avoided, and the *status quo ante* should prevail until after the election. It was however still, rightly, thought important to give incentives to hospitals and other care providers to combine meeting targets with good financial performance, and so a 'bonus' for high-performing hospitals, suggested by then-adviser Gordon Best, was put forward as a reasonable policy.

There will always be a debate about how appropriate 'targets' are, but since the dawn of targets in the mid-1990s and their institutionalisation by New Labour after 1999, oppositions which criticise them end up retaining them. In 2022, the Conervative government's plan to tackle the post-pandemic backlog in the NHS sounds very like New Labour's targets, only much less ambitious (partly understandably, given the effect of the pandemic, but also reflecting more than a decade of Conservative 'austerity').

The Department of Health: A Suitable Case for Treatment

While the central challenge for the NHS concerns access, steering from the centre is important. One of the problems of the reform era, initially

seen as a success, is the subjugation of professional independence to 'delivery'. In 2007, Greer and Jarman (2007) asked what the future of the Department of Health, after its reincarnation as 'Department of Delivery', would be. If one is to believe Dominic Cummings, Boris Johnson's former chief assistant, the answer was, 'smoking ruin'. For what was eulogised in the short term as a single-minded managerialist Department became something very different once the longer-term effects of ripping up traditional structures and approaches to policy registered. By then it was too late.

Structure is arguably not as important as behaviour, in a crisis especially—creative behaviour can overcome structural disadvantage. But over time structure may condition behaviour. The marginalisation of independent professional advice to Ministers (e.g. by the best type of civil service 'mandarin' *and* outsiders who are 'misfits and weirdos' in Dominic Cummings' phrase) was a casualty of the reforms to the Department of Health which sought to manage the NHS professionally from the top. Making the Permanent Secretary (PS) to the Department of Health and the Chief Executive of the NHS the same person did not work (as in 2000–2006): it diluted and undermined both functions.

But simply re-separating the roles and marginalising the PS altogether has not worked either: it has meant that Ministers and NHS top managers are unchallenged by independent expertise. During the pandemic, the marginalisation of the top independent professional (the PS) has had knock-on effects in diminishing the influence of complementary independent professionals in the medical and scientific fields. While some of the problems during the pandemic lay with a weak Chief Medical Officer and a weakly coordinated Scientific Advisory Group on Emergencies, the Department of Health structure was also a problem.

The organisation of the central bureaucracy, and Ministers' relations with it, have been in perpetual revolution since the 1980s. An important challenge now at national level in England is to restore the status of a genuinely independent civil service within the Department of Health and *yet* supplement it with external advice, keeping the role of managing the NHS separate.

And in terms of national-regional/local relations, professional lines of advice and public health protection (from central to local levels and the reverse) ought to run separately from general management's lines: the idea that general management ought to be so all-embracing that it silences

or marginalises contrary opinion is harmful. We have seen a control-freakery in the NHS for too long now, and the pandemic has cruelly (for the nation) exposed the shortcomings of failing to point out the true nature of the Emperor's new clothes.

Something else which has not helped is Ministerial susceptibility to hiring outside business experts to provide a quick fix to NHS or Departmental problems, or hiring NHS chiefs from the private sector. In 2021, new Health Secretary Sajid Javid was at it again, threatening to sack NHS CEOs who did not cut waiting lists to his satisfaction and replace them with business-people, despite the lists having reached over six million because of his government's having made Britain 'plague island', the country worst affected in Europe by the pandemic.

Ministers had been round this particular race-track periodically with the same result: the (usually perfectly rational) business experts came up with the same observations as those made ad nauseam by beleaguered NHS managers—essentially simple or analytically straightforward things, but which did not suit Ministers, or which cut across government policy (e.g. the purchaser/provider split), and so did not happen, whatever their provenance. At the end of the day, the tendency of Ministers to seek scapegoats for their failures trumps all.

A strong civil service, less subject to political control of key appointments as in recent years, combined with stronger professional independence within the Department of Health, will not produce magical results. But it might just help to staunch the flow of superficiality as a surrogate for policy.

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Afterword: The NHS at 75 Years Old—On the Critical List

The definition of 'protecting the NHS' during the pandemic was never adequate or consistent. As a result, 'running Covid hot' led to 'running the NHS hot'. This may take a generation to rectify, if it is rectified. In the meanwhile, private payment for speedy consultation with specialists and surgery has grown significantly. For the first time since 1948, more was spent in the private sector than in the NHS for 'cold' surgery, at 54% of the total by autumn 2021.

As a result, it is a moot point as to whether the NHS will ever return to being a (mostly) universal and comprehensive service, as much of the population will be increasingly unwilling to give up speedy access to private care yet also increasingly unwilling to 'pay twice' *i.e.* for both their own private care or private insurance and through taxation for a comprehensive NHS.

The market reforms over 30 years were barking up the wrong tree. The private sector was never good at delivering NHS services better than the public sector. Its niche was not 'Fordist efficiency' but 'post-Fordist' quality for elective surgery, ambulatory care and speedy consultation. Much of this might be technically inefficient. *But that is the point*. Excessive technical efficiency can lead to an unpopular service, which then loses political legitimacy in a vicious circle over time.

The British private sector's rationale is as an outlet for those who do not want to be denied care, or reassurance, through technocratic

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judgements as to what was and was not technically efficient and/or 'cost-effective'. The more the NHS denies *real* patient choice despite using the language of patient choice, the more it will struggle. Examples of this are easily found, for example, in drug prescription and choice of technology Often enforcing the 'cost-effective average' across the board causes difficulties for patients who need, for example, a slightly more expensive drug which is clinically similar to the cheaper one but which works better for them.

The entirely laudable aim of the Blair reforms to the English NHS was to offer the kind of choice which the private healthcare sector gave to paying customers. This was an example of how Tony Blair acknowledged the aspiration of choice and individualism but thought that Labour should extend it to all rather than leaving it to the privileged. He saw 'Old Labour' as caring more about the producer (i.e. the worker) than the consumer. And this explains the paradox of how he saw the NHS itself as 'the greatest act of modernisation ever undertaken by a Labour government' (as stated in the Foreword to the NHS Plan of 2000) yet also at risk in modern society.

If the NHS was to remain a service which was universal (open to all, *and* used by all), comprehensive (providing a very broad range of treatments, for all illness from the severe to the mild) and both convenient and timely, it would have to remain attractive to the modern *individual*. In terms of political economy, this was actually a tall order. It meant that the NHS would have to offer as good a deal for the better-off consumer (paying for his own care through taxes but also contributing for the less well-off) as he would get paying only for himself privately. This in turn meant that the NHS would not just have to be *as* efficient as the privately paying sector (it was). It would have to be *more* efficient to a significant extent.

The trouble was that 'choice' was pursued in the wrong direction in the wrong way. New Labour's expansion of the NHS came at a time of plenty, and even then failed to establish the NHS as a service capable of allowing genuine choice yet also coherent service planning. This was because New Labour, although rich in policy ideas and well-intentioned, was pursuing misconceived reforms and was poor at implementation, to boot, despite its self-image of 'what counts is what works' and 'deliverology'. Targets, yes; coherence, no. And even more importantly, the significant extra money for the NHS from 2000 to 2008 was *part*-wasted in paying for continuous re-disorganisation rather than, say, extending the

sort of patient choice 'at street level' which people sometimes have to seek in the private sector, unless their local NHS is outstanding.

Despite these flaws New Labour's days were halcyon in hindsight, by comparison with the years from 2010 onwards. And now, if even the ideal government (from the viewpoint of those who believe in the NHS) were to appear, it would be a government operating with post-pandemic debt which is greater than the annual GDP of the UK and which will take generations to pay off. It is reasonable to expect better governance than under the Johnson government, which the pandemic showed to be serially incompetent. But even so, any prognosis for the NHS has to be a sober one.

If the NHS cannot please enough of the people enough of the time so that private insurance or private payment is seen as unnecessary by the bulk of the middle-classes, then over time there will be a groundswell of opinion opposed to paying the level of tax to fund a comprehensive NHS. If they pay for private care as a matter of course, people will either expect lower taxes per se or (more likely) there will be a groundswell of opinion for tax allowances for (at least) the amount paid for private insurance. In other words, people will—eventually—be unwilling to pay twice. Tax allowances for private care were briefly introduced at the end of the 1980s by the Thatcher government, but only for the over-60s, and they did not last long. But that was an ideological spasm by a government hostile to the public sector. Today's pressures are more substantial.

To this may be added the phenomenon of younger generations who do not benefit from free secondary education and affordable housing like their parents, and are more individualistic in their approach to health-care than their 'welfare state' parents and grandparents: many of them already do not see why they should pay taxes for services from which older generations benefit more, generations which did not face the economic difficulties of today's younger people. Some of this is pure selfishness, for after all the older generations have 'paid in' over decades in the expectation of benefits in their old age. But some of it is rational. As an overall cocktail, it may leave a lethal hangover for the NHS: a tipping-point may be reached beyond which a universal and comprehensive NHS is unsaveable.

The irony is that, even with long waits and inadequate or indirect access to specialist outpatient consultations, the NHS may still be much more cost-effective than the private sector—in the round and especially for what it does well, once the worst of the post-pandemic hangover is

eventually cured. But if dissatisfied modern 'consumers'—by no means all of whom are 'middle-class'—cannot get timely, high-quality access to what they feel they need, then the above destructive dynamic may push the NHS (further) in the direction of that tipping-point.

Beyond that point, the NHS is in danger of becoming essentially an emergency service which also caters for conditions which are, if not 'catastrophic', then both serious and complex. It will continue, in addition, to offer a generic GP service which at its best is excellent but which at its worst (not a reflection necessarily on the GPs concerned) cannot offer referral to specialists in a manner to prevent the further growth of the private sector. To put it another way, cost-effectiveness is not enough to staunch demand for 'cost-ineffective' access to private consultation, testing and operations.

The demise of the NHS is not inevitable, especially if better-off citizens continue to exhibit enough altruism to augment the budget of the NHS beyond that available in the 'individualist' case (mentioned two paragraphs above) for an NHS which is efficient enough to give a better deal (both clinical and financial) than the private alternative to the modern middle-class user. But a revitalised NHS capable of being both universal and comprehensive in the age of ever-expanding (effective) therapies and drugs would be seriously expensive. It would also require enough specialists to allow direct access to ambulatory specialist care as a complement to GP care. Currently there are not enough consultants to staff existing hospitals effectively, let alone provide extended ambulatory access.

There is another problem. What economists, sounding rather Victorian, call 'moral hazard' is the phenomenon of over-consumption of free or under-priced goods. In an NHS where waiting-times exist, where prioritisation is (therefore) done by a gatekeeper such as the GP or specialist putting together a list and/or where services are 'cheap and cheerful' even when of high clinical quality, then 'moral hazard' is not a problem.

But in a quick-access NHS where the right to see a specialist on an outpatient basis without (much) gatekeeping exists, it could become a serious problem. Solving the problem through co-payment (say, for those whole illnesses are avoidable and lifestyle-related) is one option, but that brings its own problems of either inequity or high administrative costs in organising exemptions. Furthermore, co-payment for non-emergency NHS services (beyond what already exists, for prescriptions in primary care, dentistry and eye-care) would *increase* the relative attractiveness

of the private sector, and accentuate the above vicious circle. And co-payment for lifestyle-induced emergencies would be cruel-at-the-point of use, even if there were a rationale for it.

For a future where new drugs and treatments will be available at high cost (e.g. a transformative new drug for the symptoms of cystic fibrosis which costs £100,000 per annum for each individual for whom it works well), no option to save the NHS is good: it is a case of which is considered the 'least bad'.

The journey from where we are in the UK to a high-quality, easy-access, comprehensive NHS is a steep one. As a lifetime passionate believer in the idea and ideal of the NHS, the pessimistic scenario is a most undesirable outcome. But averting it does require a willingness to spend significant new money and implement the *right* sort of change.

Index

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