A view on NHS reforms

The current ‘reforms’ of the NHS arose from concern over the increasing costs of health care; mistrust of the professions, including medicine and nursing; a contrasting excessive trust in the virtues of a managerial and mercantile culture; and possibly a desire to divert criticisms away from central government down to local agencies. The shape of the reforms largely reflected expedients which had been tried in the USA, with apparent neglect of the evidence that the system there had produced exceptionally costly and inequitable health care. With no prior evaluation in this country, and against much professional advice, the reforms were pushed through, and have caused problems. Massive managerial costs stemming from the artificial market have diverted resources, and also agencies. The cost of health care from a business to a service requires abandoning the ‘market’, with its purchaser-provider split, and its imposition of a costly contractual framework on transactions which are in their nature clinical, not commercial.

For the first quarter-century of the NHS, it was spared any major organisational change; the changes were functional improvements in the role of health professionals throughout the country, not structural upheavals of the type which have occurred with increasing frequency and severity since 1973. During the first 25 years, the NHS established itself as a major component of the welfare state; as a service regarded with respect and even affection by those who worked in it and by those whom it served; and most remarkable of all, to be regarded by Iain Macleod, a senior Conservative statesman, as ‘out of party politics’. Happy days—they even seemed so at the time.

In 1974, the first seeds of present difficulties were sown, with the purest intentions, by Keith Joseph whose early genuine social concern had been overlaid by creeping monetarism, and by an unwise disregard of the American maxim, ‘If it ain’t bust, don’t fix it’. A complex ‘re-organisation’—the euphemism ‘reform’ had not been thought of—introduced an additional tier of administration at ‘area’ level. The hope that a change in structure could solve the (genuine) problems of increased medical opportunities (a good thing) and adverse demography (a bad thing) proved predictably vain. Something else had to be tried.

A decade or so later, Mrs Thatcher commissioned Roy Griffiths, a senior Sainsbury executive, to look at management in the NHS. Oblivious to any possible advantage of consensus-management in running a complex service with many professional groups, he was apparently interested only in the line-management with which he was familiar in a business concerned with concrete commodities, each with a price attached. Having defined management in such a way as to exclude that which actually existed, he naturally failed to find any; and complained—the idea of professional responsibility being apparently alien to him—that ‘no-one was responsible’. His cries fell on deaf ears; and the culture of ‘general management’ in the NHS, rejected by Patrick Jenkin, was espoused by Norman Fowler [1], ‘guided’ no doubt by the then Prime Minister. That culture has yielded a rich harvest—of managers; but it didn’t solve the problems.

As the 1980s rolled on, and costs of the NHS increased in spite of schemes such as ‘income generation’ from shopping arcades in hospitals, and competitive ‘contracting-out’ of cleaning and catering, a measure of desperation seems to have set in—how else can one explain the idea of improving the NHS by looking for a remedy to America, of all places—a country with the costliest health care in the world, which yet failed to reach millions of her citizens. Unfortunately, there was a guru to hand, with a prescription designed to appeal to anyone steeped in Reaganomics, and anxious to create a market where none was. Reflecting on the NHS from California, AC Enthoven [2] had in 1985 suggested the creation of an ‘internal market’ in which district general managers would purchase services from private hospitals and from NHS hospitals both in their own district and elsewhere. Hindsight suggests that these ideas must have influenced government thinking; but of that little is directly known, both then and later.

So much for the important background to the recent reforms, on which my general view is that they were flawed in conception; implemented with no attempt either at previous trial or later evaluation; and demonstrably damaging in many of their effects.

Flawed conception

Whether from secrecy or from confusion, the reasoning or motivation which led to the reforms is far from clear. Although the initial stimulus may have come from professional concern about the state of the NHS, expressed formally by the heads of three Royal Colleges to the Prime Minister [3], there was no overt consultation with the health professions during the preparation of the 1989 White Paper, whose title, Working for patients, is worthy of a cheer from the ranks of Tuscany. To be fair, that title does encapsulate the
aspiration of the open agenda, that the service would be improved by more effective management, by a competitive market element, and by devolution of decision making from central to local agencies. Naturally, neither the title nor the document reveals a hidden agenda; but through the fog of non-debate we can perhaps dimly discern some of its components.

There was a general mistrust of the professions, not only of doctors and nurses, but also of lawyers and teachers; and a matching faith in management and market forces; so the transfer of power from the health professionals to management, implicit in the reforms, is not likely to have arisen by chance. Devolution of decision to local agencies and to the play of competition may sound well; but Enoch Powell was not alone in seeing therein ‘a comprehensive and unprecedented attempt to achieve a limitation and “cut-off” of political responsibility’ [4]. As one of the small band of credible Ministers of Health, he has the authority to appreciate both the importance of accepting rather than evading responsibility; and the need to achieve ‘a common understanding between the healing professions and the responsible politicians’. If efforts have been made by health ministers to achieve such an understanding in recent years, they have been inconspicuous and correspondingly unsuccessful.

There is one item of a sometimes postulated ‘hidden agenda’ which I do not personally accept, that there is a deliberate attempt to weaken the public provision of health care, with a view to enhancing recourse to the private sector. Fiscal measures have indeed been introduced to cushion the costs of private provision, and that may indicate a measure of approval of an entrepreneurial private sector; but I cannot see in it anything so sinister as a wish to undermine the NHS itself. Apart from the widespread goodwill in MPs of all parties towards the NHS, the political and financial costs of engineering its failure would be unacceptably high. But what cannot be attributed to malevolence may still be attained by blundering.

Blinkered implementation

It has been suggested [1] that ‘In retrospect, however, it is clear that as Mrs Thatcher’s grip on her office began to weaken’ (something it was hard to see at the time) ‘so Ministers and their officials began to distance themselves from the stance they had been taking’. This was, however, a limited distancing, since although the competitive terminology of the market may have been softened, the market itself, and the artificial split between ‘purchasers’ and ‘providers’ remained central to the scheme. With a measure of irony, the Minister selected to push through the reforms was Kenneth Clarke, not notably ‘one of us’ (the title of a fine book by Hugo Young [5] which contains the best one-sentence description of what was done to the NHS—‘although the NHS remained a public service, its internal structure was rebuilt to import market principles into this non-market operation’). But whatever he may have thought of his task, he proved fully equal to it, in the sense of brushing aside any criticism which professionals might have regarded as ‘informed’; and in particular rejecting any proposals for monitoring and evaluation, expressing the view in his 1989 evidence to a Select Committee that calling on the advice of academics was a sign of weakness [6].

Simply because it comes readily to hand, and without imputation of merit, but as a sample of the widespread misgivings among doctors at the time, let me quote something which I wrote in this journal early in 1989 [7], after my first encounter with Working for patients:

‘Let me now explain why I believe that what may be appropriate for a chain-store is no way to run a health service. The root of the matter lies in the deeply personal nature of the service which has to be given, which demands a conjunction of human sympathy and professional skill which cannot be replaced either by a cash-dominated transaction or by a diktat from a manager whose first concern is with ‘economy’ rather than quality of service. It cannot in the long run be a true economy to curtail the clinical activity of doctors and nurses, or to turn our hospitals into autonomous collections of empty wards and theatres on top of a shopping centre.’

It is, of course, entirely possible for health professionals to be mistaken, though neither is it certain that they must be so; and the likelihood may be less when doctors and nurses express similar considered views. It is also possible that a scheme which has been heavily criticised may turn out well in practice—the birth of the NHS itself was not universally acclaimed by medical representatives. So, are the reforms to be regarded as the great success claimed by their sponsors; an experiment which cannot yet be judged; or a mistake which is only redeemed from total disaster by the limitation of damage achieved by the continued dedication of doctors and nurses?

Early appraisals

Official views on how things are going are simple to the point of possible deception. After a bruising implementation by Kenneth Clarke, the government then found a Secretary of State prepared to encounter every criticism with a well-worn, but irrelevant, statistical handbag. When this approach falls foul of inconvenient facts, lesser mortals are on hand to say that it is too early to judge, and that when all hospitals and other organised ‘providers’ are ‘Trusts’, and all family doctors are ‘fund-holders’, everything in the NHS garden will be lovely. None of this amounts to systematic evaluation, and the government could merely claim discreditable credit for consistency in
rejecting monitoring and evaluation both in prospect and in retrospect.

Others have been less complacent, and as early as the summer of 1989 the King's Fund made evaluation of the effects of the reforms ‘the focus of a major grants programme’, which attracted 72 applications, of which six were selected for funding [6]. The results to date have now been published by the King’s Fund Institute [8] with the claim that ‘On the basis of detailed empirical research, this book offers an initial evaluation of all these claims’ (by government) ‘as well as examining their impact on the equity of health care delivery, about which the government has been silent’. It would be a folly to try to summarise what is itself a condensation of the results of several years of work by teams of experienced investigators. Individual chapters consider the operation of ‘the market’; the performance of Trusts; the effects of GP fund-holding; medical audit; and the care of the elderly. Margaret Whitehead looks at ‘the equity implications of the NHS reforms’; and has some difficulty in finding them; and there is a concluding chapter by Julian Le Grand which gives a cautious general opinion. As a good academic, Le Grand points out how difficult evaluation is in general: and how this particular evaluation is bedevilled by confounding factors such as the increased funding which coincided with the start of the reforms; changes in the GP contract; and the nourishment of expectation by the Patients’ charter. He looks for evidence of promised benefits such as greater efficiency, better quality, increased choice, and greater openness; and finds little that is concrete. But he sees evidence that ‘many hospitals are in competitive situations’ and that ‘Trust managers are looking for efficiency improvements’. In spite of there being ‘little actual change of any kind’, he judges that some of the research results ‘suggest that, at least in some areas, there is potential for real gains arising from the reforms’. And in what is at least formally an uncontroversial statement, he conserves the taproot by saying, ‘What everyone would agree on is the need for more research’.

Other commentators are less enthusiastic. In a penetrating analysis of the attempt to control escalating health costs by ‘using competition to increase efficiency’, Donald Light [9] lists ten respects in which an artificial ‘medical market’ deviates from the true market whose advantages were proclaimed by Adam Smith. High transaction costs; an ill-defined ‘product’; and the substitution of proxy ‘purchasers’ for true ‘buyers’ would suffice to differentiate the NHS ‘market’ from a true market; so that Adam Smith’s beneficial ‘Invisible hand’ is truly invisible, being absent. Light points out that the more efficient use of hospital beds, sometimes credited to the reforms, was well under way during the 1980s.

Calum Paton [10] exposes ‘perverse incentives’ arising from the NHS reforms. ‘Purchasers’ short of funds may ‘pass the buck’ to ‘providers’ in the form of broad contracts, recognising that ‘We’re safe in the knowledge that it’s hospitals to which the public complains’; but if they—more sensibly—enter into detailed joint planning with providers, they are incurring the ‘split’, and also increasing management costs. Another example out of the eight listed, is ‘shifting costs’ by purchasers who give tenders preferentially to ‘community providers who pay doctors by the session’, rather than to hospitals with their fixed costs and tenured staff. The criterion for allotting care to hospital or to community should be clinical need and quality of provision, not raw cost. More generally, he draws attention to disaggregation of what was a unified service, making it more difficult to achieve a proper balance between ‘prevention’ and ‘cure and care’.

Before concluding with a brief ‘incautious’ general opinion, let me emphasise that the appraisals which I have just quoted have been the product of policy analysts, not of doctors or of nurses. That fills me with cautious hope that they may carry some weight with politicians who have been notably deaf to claims made by those who actually work or have worked in the service.

A personal view

I have argued at some length elsewhere that the basis of a health service should be altruistic cooperation and not commercial competition [11]; and that the reforms have enhanced the role of line-management, and correspondingly devalued clinical judgment, to the detriment both of patients and of society which bears the cost [12]. The reforms have done nothing to narrow the gap in health between rich and poor [13]; and they have produced an extravaganza of finance-driven contractual bureaucracy, for which the Health Authorities Act will bring no greater amelioration than any of the previous reorganisations from 1974 onwards.

For the immediate future, the priority can only be damage limitation in the interests of patients. For the longer term, the choice is between more and more managerial devices, in the attempt to wring some clinical and social good out of a witless market; or a frank admission that as a potential regulator of health care the market has proved inadequate or worse, and must be excised, together with the whole overblown apparatus of purchasers, providers and contracts. Although scientific medicine (now often termed evidence-based medicine) only occupies a small part of the total clinical responsibility, its growth must be encouraged, with some of the resources released by cutting back on the pseudo-financial function. Similarly, additional resources must be channelled into research and development related to the provision of health services [14]. The pursuit of this second course will take time and resolution; but if resolution could be mustered, as it has been, for complexity and disaggregation, surely it could be mustered for a return
to the simple principles which brought success to the first 25 years of the National Health Service.

References

1 Butler J. Origins and early development [of the reforms] Chapter 1. In: Robinson R, Le Grand J (eds). Evaluating the NHS reforms. London: King’s Fund Institute, 1994;pp13–23.
2 Enthoven AC. Reflections on the management of the National Health Service. Occasional Paper 5. London: Nuffield Provisional Hospitals Trust, 1985.
3 Hoffenberg R, Todd PI, Pinker G. Crisis in the National Health Service. Br Med J 1987;295:1505.
4 Powell E. Challenges for the National Health Service. In: Teeling Smith H (ed). Innovative competition in medicine. London: Office of Health Economics, 1992;pp97–101.
5 Young H. One of us. London: Macmillan, 1991.
6 Robinson R. Introduction. In: Robinson R, Le Grand J (eds). Evaluating the NHS reforms. London: King’s Fund Institute, 1994;pp1–12.
7 Black D. A Black look at a White Paper. J R Coll Physicians Lond 1989;23:66–7.
8 Robinson R, Le Grand J (eds). Evaluating the NHS reforms. London: King’s Fund Institute, 1994.
9 Light DW. Escaping the traps of post-war Western medicine. Euro J Public Health 1995;3:281–9.
10 Paton C. Present dangers and future threats: some perverse incentives in the NHS reforms. Br Med J 1995;310:1245–8.
11 Black D. The NHS: a business or service? Threatened values (leading article). Proc R Coll Physicians Edinburgh 1994:24:7–14.
12 Black D. A doctor looks at health economics (OHE Annual Lecture, 1994). London: Office of Health Economics, 1994.
13 Whitehead M. Is it fair? Evaluating the equity implications of the NHS reforms. In: Evaluating the NHS reforms. London: King’s Fund Institute, 1994;chapter 9, pp208–42.
14 Culyer AJ, Peckham M, Cooper J. Supporting research and development in the National Health Service. J R Coll Physicians Lond 1995;29:216–38.

Address for correspondence: Sir Douglas Black, The Old Forge, Duchess Close, Whitchurch-on-Thames, Nr Reading, RG8 7EN.