



Rejuvenate or retire?

Views of the NHS at 60

Editor: Nicholas Timmins



The Nuffield Trust
FOR RESEARCH AND POLICY
STUDIES IN HEALTH SERVICES

*This is the biggest single experiment
in social service that the world has ever
seen undertaken.*

Aneurin Bevan, 7 October 1948.

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“All the key players of the last decades are here, recalling the perpetual struggle to keep up with patients’ ever-rising expectations, to squeeze value from every pound spent and to prove the NHS idea can outlive us all. Succinct, pithy and memorable, this is a riveting window on the ever-revolving and -evolving NHS debate.”

Polly Toynbee, journalist and social commentator

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The Nuffield Trust

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FOREWORD

It has been a great pleasure to put this book together. Nick gamely put off his sabbatical, climbing peaks in Scotland, to do it. The contributors entered into the spirit by giving us rich contributions at short notice, many giving generously with their time to be interviewed, and others putting finger to laptop during impossibly busy schedules. The result, I hope you will agree, is a set of thoughtful reflections, by no means uncritical, which provide a good historical marker of the NHS at 60 years old, and pause for thought. We were particularly interested in reflections from those who had been in a national position to shape the health service; in particular former secretaries of state, permanent secretaries, and chief executives of the NHS, as well as a more eclectic selection of significant others.

Set out in part chronologically, there are two startling patterns to the contributions. First, the extent of consensus not only about financing, but also on many matters of organisation. Given the experience and quality of thought apparent, it is difficult not to yearn for a non-partisan ‘fantasy ministerial team’ to be at the helm, at least for a short period. Second is the importance of ‘journey’, with events unfolding as opportunities and constraints at the time allow, and of the need to learn from this to shape the next phase. It will be important to learn from the experience of the NHS in Scotland, Wales and Northern Ireland, which have pursued different paths. Most of the contributions in the book are focused on the English NHS, in part due to the unusual and more controversial set of reforms implemented there.

One of the most memorable sentences in the book, reported in Sir Kenneth Stowe’s contribution, was the one famously uttered by Margaret Thatcher after hearing radical plans to

reform the NHS, including its financing: “There is no constituency for change.” As Sir Kenneth put it: “End of message.” Public support for the underlying principles of the NHS remains as strong today, principles rooted in the fact of general taxation being the main source of financing. Funding from this source is probably the main reason why the NHS is envied abroad – the ability to control costs effectively, perhaps too effectively. Public support and effective cost control are unlikely friends in health systems across the globe, but the NHS continues to keep them on good terms. It would be political suicide for a party to turn its back on that, even if attractive alternatives were available, which they appear not to be.

However, collective financial parsimony relative to individual changing expectations is the challenge. How much spending is enough? Healthcare is to an extent a discretionary good, as pointed out in Henke’s contribution the richer a country is, the

“What has changed is the balance between the collective and the individual in society... and that is a challenge for the health service. To recognise that is not to walk away from its collective aspiration which... is overwhelmingly right.”

Rt Hon. Stephen Dorrell

more it spends on healthcare (publicly or privately). Given current trends, at some point this century (probably just after midway) the percentage share of gross domestic product (GDP) devoted through public funds must plateau. Demand for healthcare beyond that limit would have to be financed through other means.

This has been a story told for at least a decade. Many have noted the obvious self-interest of some of the soothsayers in suggesting the erosion of tax funding, and alternative sources to top it up. The contributors of this book are divided as to whether the evil day will occur at all. Some believe the day will be saved by new technologies forcing

hitherto undreamt of efficiencies. Others are more pessimistic. There is more consensus that public funding will continue as the basic main model. Alan Milburn used almost the same words as Stephen Dorrell, who said:

What has changed is the balance between the collective and the individual in society... and that is a challenge for the health service. To recognise that is not to walk away from its collective aspiration which... is overwhelmingly right.

It may not just be right, but pragmatic too.

In the meantime the hunt is on, at home and abroad, for value for money in a way that does not jeopardise equity access or public satisfaction. The chess board and objective are the same, but the pieces are in different positions in each country owing to history, values and context. In a recent, highly insightful analysis of reforms of healthcare across 11 developed countries, Bob Evans wryly notes the overall lack of progress in tackling one major area – modifying provider and clinical behaviour – because of the power of the professions to contest needed change “in the struggle for the hearts and minds of the population”. However, as he challenges, “cost control involves modifying physicians’ behaviour as much as, if not more than, limiting their incomes”. If cost-containment leads to “head-on” conflict

over “professional organisation and autonomy” he warns, “reforming governments do not generally receive broad public support”. It is not surprising to find, as Alan Maynard noted in a similar review, that across Europe in the last decade, reforms of healthcare across have focused on the demand-side (for example, increasing co-payments) rather than supply-side – yet the latter is surely where profound gains are to be made.

The innate, profound and consistent conservatism of the medical profession to change, as demonstrated historically by many of its leaders, comes across loudly in a number of contributions to this book. To cite Sir Kenneth Stowe again, reflecting on the slow progress to improve quality and failure to implement the recommendations of the Griffiths Inquiry, “It says it all. There is a failure of medical leadership. It could have been theirs but it wasn’t.” Why are so many doctors blinkered when it comes to improving services rather than just the treatments of the individuals in front of them? The talent is there, and there are encouraging signs, but unless the sleeping giant can be roused there cannot be much hope of a step-change in the cost-effectiveness of healthcare. That must be the major challenge for the NHS at 60 and beyond.

Surely the key lies less through a series of head-on national conflicts with government over specific policies, and rather through policies

that promote ongoing internalised behaviour modification at the grass roots through some combination of clinicians taking responsibility for a local budget, information advances allowing more self- and peer-scrutiny of performance, and competition on outcomes. William Waldegrave must be right when he says in the book, “we’ve somehow trapped people in a structure which isn’t working” – something which applies as much to politicians as doctors. The challenge will be to design reforms to ‘untrap’ without warfare with the medical profession. Thus the journey is likely to be steady advance than big bang. Without it, the collective model will be eroded.

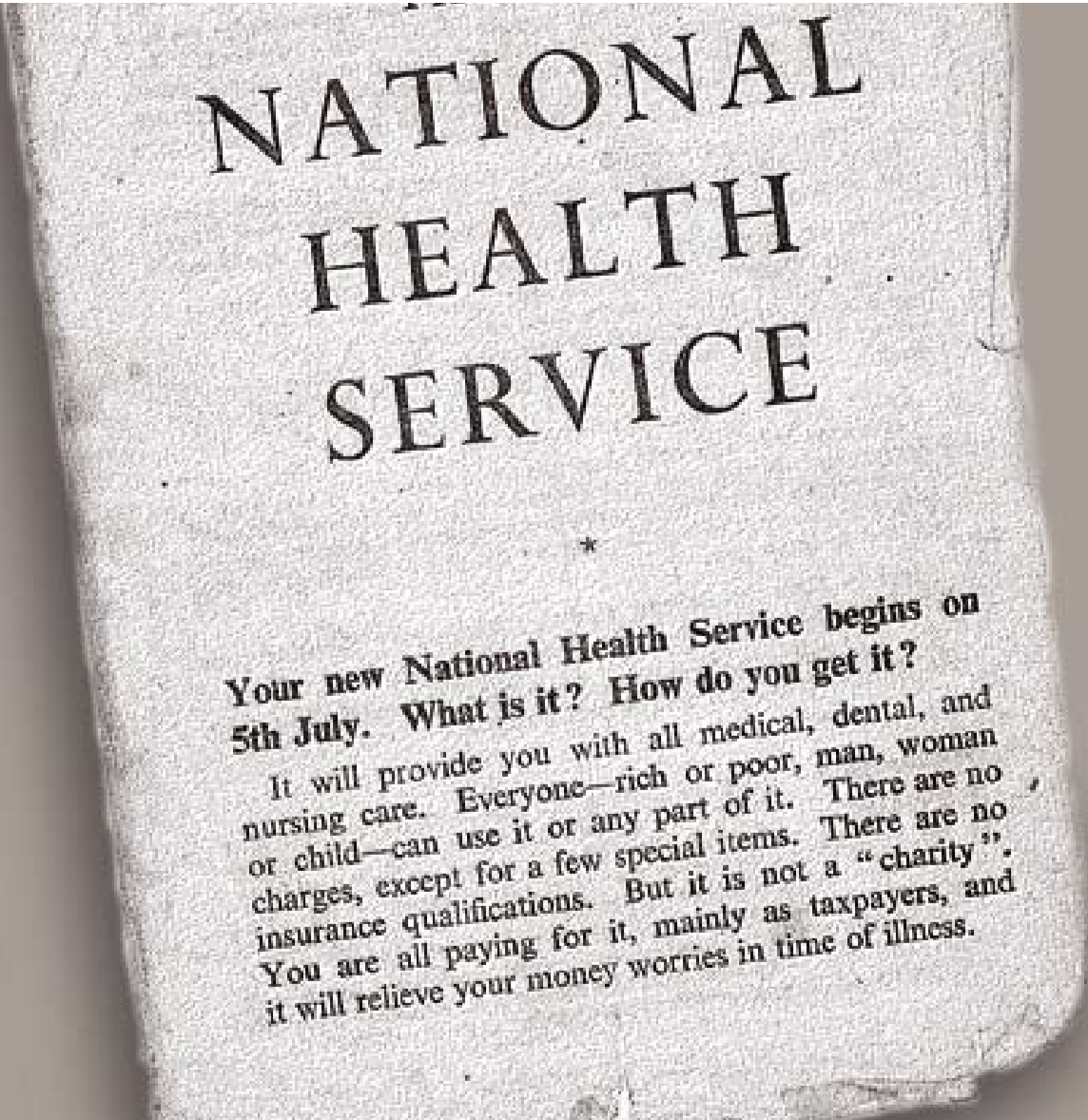
The Nuffield Trust is hugely indebted to Nick Timmins for many late night hours of work putting the book together (on top of a day job) and for unfailing good humour. Matthew Batchelor was the thoroughly conscientious project manager who also worked long hours with patience and care. Many thanks also to Angelique Buhagiar, Catrin Rees Ferreira and Kate Uvelli Howe at The Nuffield Trust for support on practical matters. Finally, of course, a huge thank you on behalf of the Trust and the *Financial Times* to the contributors for responding so generously and well. We may return to them for the next instalment 10 years from now.

Dr Jennifer Dixon
Director, The Nuffield Trust



OVERVIEW

The NHS at 60 – calm before the storm?



NATIONAL HEALTH SERVICE

**Your new National Health Service begins on
5th July. What is it? How do you get it?**

It will provide you with all medical, dental, and nursing care. Everyone—rich or poor, man, woman or child—can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. But it is not a “charity”. You are all paying for it, mainly as taxpayers, and it will relieve your money worries in time of illness.

Nicholas Timmins

Nicholas Timmins is Public Policy Editor of the *Financial Times*. He is Visiting Professor in Public Management at King's College, London, a senior associate of The Nuffield Trust, and President of the Social Policy Association.

The National Health Service has never been good at celebrating its big anniversaries. The tenth, in 1958, was a matter of quiet congratulation. The debate in the House of Commons – the only Commons debate there has ever been to mark an anniversary – acknowledged that there were many problems still to be overcome. Nye Bevan, it is true, could not resist a few pointed, although generally good-humoured, jibes at his Conservative opponents. However, the sense that something big and good had been created in 1948 was strong.

Derek Walker-Smith, the now long-forgotten Conservative health minister, declared that the country was “getting a good bargain for the very large amount of money” that the health service was costing. On the day, he became one of the first (although very far from the last) to try to prove that progress with a litany of statistics. Beds were up by 6.5% since 1949. Inpatient admissions were up by 29.5%, suggesting that even then, length of stay was shortening. The ratio of treatment to beds was up by 22% – productivity

was already an issue. Outpatients were up by 12%. Waiting lists were down by 11.5%.¹

However, even that anniversary was calm, measured and comfortable only because the NHS had just weathered the first of its many major crises. Expenditure after 5 July 1948 had far exceeded the estimates. Even Bevan in 1949 had declared, “I shudder to think of the ceaseless cascade of medicine which is pouring down British throats at the present time.”² Throughout the early 1950s the sense had grown that an all-consuming beast had been created in the NHS: one subject to widespread abuse which was ultimately unaffordable and unsustainable – as the critics argued, any “free at the point of use” service had to be.

It had taken the Guillebaud report of 1956 to kill that argument off – even if, as we now know, it only killed it off for a time. Dry, detailed and heavily researched, the report pointed out that, far from being out of control, in fact the NHS was taking an appreciably smaller share of national income than it had in its first full year of operation in 1949. If spending in 1953 had matched 1949 levels, it would have been £67 million (one-sixth) higher. The committee had been set up by the Treasury in the hope that it would recommend curbs in expenditure. However, Guillebaud turned out, so to speak, to be the Wanless of his day. Far

1. Hansard, HC 30 July 1958, Vol. 592, Col. 1401.

2. *The Times*, 26 October 1949.

from recommending cuts, the report highlighted instead an issue that was to plague the NHS for much of the next 50 years: its lack of capital. Capital spending, Guillebaud said, was running at one-third of the level that it had been in the pre-war days of the voluntary and municipal hospitals. It called for a trebling of capital expenditure to £30 million a year. Far from recommending reductions in expenditure, the committee concluded, “we have found it necessary to make recommendations... which will tend to increase future costs”.³ It almost goes without saying that such a sharp rise in capital expenditure was not immediately forthcoming. Nonetheless by 1958, Iain Macleod, the still-rising Conservative star who already had been minister of health, could declare that the NHS was, “with the exception of recurring spasms about charges”, now “out of party politics”.⁴ Two-thirds of doctors polled in 1958 declared that, given the chance to go back 10 years and start again, they would support the creation of the service.⁵

However, the 20th anniversary in 1968 was quite another matter. The first pharmaceutical revolution – antibiotics – had been followed by a second. That included the contraceptive pill, treatments for asthma, the serious antidepressants that would eventually permit the rundown of mental hospitals, and the less serious ones that were

marketed by the less responsible pharmaceutical companies as “happiness pills”, which the Rolling Stones dubbed “mother’s little helper”. It was in 1968 that two leading health economists noted that “ninety per cent of today’s medicines were totally unknown in 1938, and fifty per cent were unknown only five or six years ago”.⁶

Kidney transplants and dialysis had been around for a time, but they were costly. Cervical smears and other new technologies had arrived and in 1968, just weeks before the 20th anniversary, the first British heart and liver transplants took place. Not long before, Enoch Powell, in his famous 1966 book *Medicine and Politics*, had popularised the (highly debatable) theses of “an infinity of demand”. There was, he declared, “virtually no limit to the amount of medical care an individual is capable of absorbing... in short, the appetite for medical treatment *vient en mangeant*”.⁷

The sense was powerful then – as for some, it remains even more powerful today 40 years on – that the NHS was at the mercy of a pharmaceutical technological revolution that it could not afford. The 1968 Budget had seen Roy Jenkins, the chancellor, reintroduce prescription charges. Barely a year later Richard Crossman, whose appointment as the first Secretary of State for Health and Social Services saw health regain a

3. Report of Committee of Inquiry into the Cost of the National Health Service. Cmnd 9663, London: HMSO 1956, para. 721.

4. *The Future of the Welfare State*, Conservative Political Centre, 1958.

5. Klein R. (from Gallup Polling). *The New Politics of the NHS* (5th edn). Oxford: Radcliffe, 2006.

6. Cooper M.H., Culyer A.J. *Health Services Financing*. London: BMA, 1968.

7. Powell E. *Medicine and Politics*. London: Pitman, 1975, pp. 26–7.

Cabinet post for the first time since Bevan's day – a mark of how economically important it had become – used a 1969 lecture to set out the rise in welfare state spending generally since 1950. If the graphs were extrapolated, he said, “the prospects before us are truly terrifying”. Amid all this new technology, he declared, with the numbers of elderly growing (as well as a baby boom at the time), and with “a revolution in expectations” underway, those pressures

*will always together be sufficient to make the standard of social services regarded as essential to a civilised community far more expensive than that community can afford... there is no foreseeable limit on the social services which the nation can reasonably require, except the limit that the Government imposes.*⁸

If the 20th anniversary fell victim to what Rudolf Klein has neatly defined as a mix of “technological pull” and “demographic push”, the 30th in 1978 was worse. The years immediately before it had seen both consultants and junior doctors take extended industrial action for the first time over pay and hours. The action closed Accident & Emergency departments and significantly extended waiting lists. These two profession-dividing and soul-destroying disputes took place alongside a bloody, two-year, knockdown battle between the doctors, the Government and the health trade unions over Barbara Castle's plan to

remove pay beds from the NHS. Only a year or two before Dr David Owen, the health minister, had noted “alarming” projections that if the rate at which NHS staffing had grown for the past 20 years was sustained, then by 2010 the whole national workforce would be employed by the NHS. Clearly, that was not sustainable. Partly in response to all this turmoil, the Government had set up a Royal Commission on the NHS.

Owen was later to reveal that he and Castle⁹ had ‘fixed’ the membership to ensure it would not recommend a change to the funding system – but no one knew that then. While it fulfilled Harold Wilson's famous dictum that royal commissions “take minutes and last years” – it did not report until 1981 – the mere fact that it was sitting helped to fuel the sense of unease that the NHS model might not be sustainable. As if to prove the point, within months of the anniversary David Ennals, Castle's successor, became the first health secretary – and a Labour one at that – to be sued by patients for failing to provide a comprehensive service because they could not get a timely hip replacement.

The 40th anniversary in 1988 proved no more a moment for jazz bands and self-congratulation than the 30th. 1987 had seen not just the triumphant re-election of Margaret Thatcher for an unprecedented third term, but the worst financial crisis in the NHS's history – one that makes the

8. Crossman R. Paying for Social Services, Herbert Morrison Lecture, *Fabian Tract* 1969: 399.

9. Secretary of State for Health, 1974–76.

recent £571 million deficit in England on an £80 billion budget look like a ripple on the pond. On a budget less than one-quarter of that, the NHS owed its suppliers alone close to £400 million – around one-quarter of the total non-pay budget in some districts. On top of that, pay rises had been underfunded by another £150 million, there were other budget pressures and the situation was so bad that Ian Mills, the Department's director of financial management, had to screw up the courage to tell ministers brutally that the NHS was "technically bankrupt". Thousands of beds closed as health authorities struggled to balance the books. Doctors marched on Downing Street. The presidents of the three senior royal colleges – in an echo of the 1940s when their joint intervention had helped to create the NHS in the face of British Medical Association (BMA) opposition – united again to appeal in public to the Government to "save our NHS".

The result in early 1988 was the NHS Review, announced on *Panorama* by Margaret Thatcher. It was that review which led to the 1991 internal market. However, on the way – and at the time of the 40th anniversary – it was still looking at alternative funding systems. As Kenneth Clarke recalls, the 40th anniversary, insofar as it was even noted, was "chiefly turned into a political campaign against us by the unions, arguing we were planning to sell the NHS off and they wished to mark its demise".¹⁰

The 'Big 50' in 1998 was officially recognised, but the celebrations were muted. A slightly dusty and wary event was held in the cavernous echo of Earls Court, attended by Tony Blair, the prime minister. However, the hall's very acoustic appeared to reflect what was beginning to feel like an increasingly hollow promise, as the cumulative effect of decades of underspending, compared to that in other European countries, was coming home to roost. Spending was stretched tight as a drum. Everyone – the politicians and those in the service – knew that what eventually proved to be the winter 2000 crisis was just around the corner: the one when a minor dose not even of proper flu, but of a couple of nasty respiratory infections, led to mayhem on the wards and bodies having to be stored in freezer lorries at one East Anglian hospital.

If this brief history of the big anniversaries demonstrates *plus ça change* – that many of the issues that the NHS is grappling with right now, and will continue to grapple with, always have been there – it might also explain why the 60th is attracting so much attention. Most of the politicians interviewed for this exercise expressed themselves bemused at the degree of interest. All said that they had been inundated with requests for interviews or pieces for publication. Grand reunion dinners of ex-permanent secretaries and former NHS chief executives are being held. Not only The Nuffield Trust but plenty of others

10. Interview with Kenneth Clarke, Secretary of State for Health, 1988–90, p. 44.

are producing publications, running seminars or holding debates – time for the NHS to retire at 60, or renew?

William Waldegrave¹¹ suggested it may be a sort of Second World War effect: that the further the country gets from 1945 (or in this case, 1948), the bigger and more nostalgic the celebrations. However, the real explanation probably lies elsewhere. On the surface, and for this anniversary, currently the NHS is cradled in a rare cross-party consensus about both its funding and its shape. David Cameron, the Conservative leader, has signed his party up in blood to preserving the NHS as a tax-funded, largely free at the point of use service. If we are to believe him, for the first time since 1948 the Conservatives are not secretly looking in opposition at charges, top-up fees or a switch to insurance or some other funding change, even if only once have those exercises ever led to such a proposal being put to the electorate: the opt-out and top-up proposal of the ‘patient passport’ that the Tories offered in 2005. Also, on the issue of how the service should be run, there is remarkable cross-party agreement. Certainly, the Conservatives want, for example, a national arms-length board to run the NHS. They have far more faith in general practitioner (GP) commissioning than Labour appears to exhibit. The Liberal Democrats would like to hand commissioning over to local authorities – an idea

that some Labour politicians are starting to find attractive.

These differences could lead to very different outcomes. However, they are managerial, technological differences about how to run the service, not ideological ones. All the main parties – the Liberal Democrats included – now see the NHS being run with at least some greater degree of market discipline than in the past, becoming more a commissioner of services and less of a provider, with a greater injection of private and voluntary providers into the mix. The differences between the parties are essentially ones of pace, scale, degree and final destination, rather than direction of travel.

Yet beneath this smooth political surface – spats about polyclinics aside – the old, troubling currents that ask questions about the sustainability of the NHS (and indeed of healthcare systems worldwide, given that the French one is bankrupt, the American one is broke and the German one is struggling with reform, and so on) still run deep. The pressures first clearly spelled out more than 50 years ago in the Guillebaud report – ageing populations, the cost of technological advance and rising expectations – remain. On top of that is how far the results from Labour’s big and bold decision deliberately to increase expenditure – at a time when almost all other countries were struggling

11. Secretary of State for Health, 1990–92.

to restrain it – has paid off. Over the past decade, expenditure has risen threefold in cash terms and doubled in real ones, after allowing for inflation. Undoubtedly, the NHS has improved. The very longest waits have been eliminated. Finally, and at long last, average waits are now falling sharply too.¹² To use Alan Milburn’s¹³ graphic phrase from 2000, the service may no longer be in “the last chance saloon”. Nevertheless, if it is no longer in there drinking deep, it is not yet clear how far it has managed to walk away from the door – and whether, like a tired alcoholic, it might not be drawn back in.

The Healthcare Commission recently reported that patient satisfaction with the NHS is rising, but it is doing so painfully slowly. Of patients, 90% rate their care as good or better, but in the six years to 2007 there has been only a four percentage point rise to 42% in the proportion who rated their care to be “excellent”, despite all the extra spending and staffing.¹⁴ Quality too has risen. Sheila Leatherman and Kim Sutherland¹⁵ reported recently, at the end of The Nuffield Trust’s decade-long study of the issue, that “unquestionably” the past 10 years “have seen significant changes in quality that have made a real difference to patients and the public”. However, even such

self-confessed admirers of the NHS question “whether the gains are commensurate with the investment that has been made”.

Even if there is now a political consensus on funding, there is not one among the policy ‘wonks’ and pressure groups. As the essays in this book make clear, it is not just the private health insurers who (unsurprisingly) think that there should be more insurance.¹⁶ Think-tanks who favour the Right such as Civitas, those who would claim to be apolitical but are market-orientated such as Reform, and some of the more thoughtful NHS analysts such as Chris Ham¹⁷ and Adair Turner, who was an adviser to Tony Blair in the early stages of reform, in various ways suspect that the funding system either needs to change or will be forced to, at least at the margins.

Notably – with Kenneth Clarke the big and bold exception – some former Conservative health ministers also tend to believe that the system cannot last, or should not last – although all of them see the possibility of any actual change being remote.¹⁸ To put it another way, as Patricia Hewitt does, such ideas may still be around, “but they have not got any political traction”.¹⁹ So these factors – the longstanding pressures of

12. NHS Inpatient and Outpatient Waiting Times, 30 May, reported in *Financial Times*, 31 May 2008.

13. Secretary of State for Health, 1999–2003.

14. Healthcare Commission. National Survey of Inpatients 2007. Available at: <http://www.healthcarecommission.org>.

15. Leatherman S., Sutherland K. *The Quest for Quality: Refining the NHS Reforms. A Policy Analysis and Chartbook*. London: The Nuffield Trust, 2008.

16. See Val Gooding’s contribution, p. 151.

17. See p. 153.

18. See interviews with Patrick Jenkin, Norman Fowler, Kenneth Clarke, William Waldegrave and Virginia Bottomley in this book.

19. Interview with Patricia Hewitt, p. 83.

medical technology, ageing populations and rising expectation, the question of whether the NHS has delivered enough for all the extra spending, and the mere fact that old arguments have not gone away despite the extra cash – may explain the intense interest in the 60th anniversary. The question lurks: ‘If it does all look pretty calm right now, is this merely the calm before the storm?’ Or, in the case of the NHS – given that at times it seems to live in a perpetual crisis – ‘Is this merely the calm before the final storm?’

Any 60th anniversary demands, however briefly, some assessment of how good or bad the NHS has been. Over the years British politicians, of whatever political party, have been unable to resist declaring it “the envy of the world”. However, the British public no longer believes that, and neither should it.

International comparisons of healthcare outcomes are fraught with difficulty. On the latest – admittedly, not entirely up-to-date figures and ones that miss the impact, for good or ill, of the last few years of sustained spending growth – the UK still lags badly behind leading comparator countries on some measures, notably on five-year survival and mortality rates for a string of major cancers. Its performance on circulatory disease is comparable to Australia, Germany and the USA, but appreciably worse than France. It has high perinatal mortality rates, low death rates from

diabetes, and a decidedly mixed picture compared to others in dealing with strokes.²⁰ Furthermore, this is a service where, well into the 21st century, some hospitals still subject patients to mixed-sex wards and where, in some parts of the country, finding a doctor out-of-hours is a nightmare. It is a service still organised in such a way that there remains a 1 in 100 chance that, once in hospital, your elective operation will be cancelled at the last minute for non-clinical reasons – and that you will stand a 7% chance that the operation will not be rearranged within 28 days. It is one where, in 2007, one-fifth of inpatients surveyed – the equivalent of more than 2 million patients a year – said they were not always “treated with respect and dignity”. Stunningly, it is a health service where, in 2007, almost a quarter of hospital staff (24%) said they would not be happy to have their care provided by their own organisation. As with everything else in the NHS, this varies. In some trusts, fewer than 2% of staff say that, but in one or two of them, the figure is well above 40%.²¹

If that is the downside (or part of it), there is plenty on the upside to stave off false despair. Health inequalities have proved remarkably persistent and there is much variation in the NHS – as there is in all health systems – in the quality of care. However, the NHS still provides some of the best medicine in the world. It has a reach through its universal coverage that many US policymakers envy, and more than 90% of patients rate their

20. Leatherman and Sutherland, *Quest for Quality*.

21. *National NHS Staff Survey, 2007*. London: Healthcare Commission, 2008.

"It is amazing to look back and realise how primitive it was compared to today's system. There are always people in the service who fondly look back to some alleged golden age."

Kenneth Clarke

hospital care as at least "good", while the British public's love affair with its family doctors (despite the rapidly changing nature of general practice) continues undiminished. Furthermore, in every year since 1948 – with the exception of those plagued by industrial action – the NHS has treated more patients, more effectively and with more modern techniques and technologies.

If there ever was a 'golden age' then it is, so to speak, now – just as it has been 'now' for pretty much every day since the service was founded. It has managed to fulfil Bevan's great dictum at the time of its launch. "We shall never have all we

need," he said. "Expectations will always exceed capacity. The service must always be changing, growing and improving – it must always *appear* inadequate."

Kenneth Clarke says:

It is amazing to look back and realise how primitive it was compared to today's system. There are always people in the service who fondly look back to some alleged golden age. But it certainly was not enjoying any golden age in the 1960s, when I was a parliamentary candidate.

To put it another way – and to insert a personal story – one of my first press conferences as a health reporter in very short trousers was in 1974 with the BMA. Derek Stevenson was its charismatic secretary. A former lieutenant-colonel in the Royal Army Medical Corps, he had dashing Rex Harrison-like good looks, immense charm, was sometimes dressed in a morning coat and striped bags. To show how times have changed, he frequently conducted press conferences (no TV cameras were allowed in those days) with an ashtray before him while chain-smoking untipped Senior Service cigarettes. Spending, yet again, was under pressure. Nurses were taking industrial action for the first time. Beds were closing. Stevenson demanded a Royal Commission and a

“So when ministers asked how we were doing, given our low level of expenditure, the efficiency measures were misleading, and the health outcome measures weren’t there. But the health status measures that we did have looked all right.”

Clive Smee

£500 million cash injection – a huge sum when the service was then costing £3 billion a year. He trailed ideas for hotel charges, top-up insurance, charges for visiting the GP or even a sweepstake or national lottery. “I do not know what the answer is,” he said, but “the fundamental thing is that it cannot go on like this.” He added thunderously, “And I am here to tell you that morale has never been lower.”

Well, I am here to tell you that almost every day that I’ve reported on the NHS since then, “morale

has never been lower”. It is also true that no health system realistically can expect to be the best at everything all the time – and none is. Every attempt to rank health systems internationally, whether by the World Health Organization (WHO) or by academics, has proved highly contentious – in the case of the WHO’s 2000 exercise,²² so contentious that it has yet to be repeated. How you rate a system depends on which of the various aspects of a quality you value most highly – whether it be access to care, relevance to need, effectiveness, equity, social acceptability or efficiency.²³

It has to be asked how the UK came to fall further behind on health quality indicators than it would want to be, particularly when undoubtedly it was seen throughout much of the 1980s and early 1990s, if not as “the envy of the world”, then at least as one of the more effective and efficient healthcare systems. The answer from Clive Smee, Chief Economic Adviser at the Department of Health between 1984 and 2002, is the combination of a failure of analysis and a certain British complacency. Until the early 1990s, he says, the data upon which international health comparisons could be made were weak. Countries had life expectancy, perinatal and infant mortality rates and years of life lost on which to make comparisons. However, these are affected at least as much by lifestyle and living conditions as they

22. WHO study of world health systems 2000.

23. See Robert Maxwell’s excellent definition of quality in Dimensions of Quality Revisited: From Thought to Action. *Quality in Healthcare*: 1(3) 1992 171–7.

are by healthcare. There were no good data on health outcomes. Added to that, he says, the UK misled itself on some of the activity data. In the 1980s the NHS switched from standard measures of length of stay to finished consultant episodes, which had the effect of artificially boosting activity (because one hospital spell could involve more than one consultant episode). This was recognised for internal UK purposes, but less clearly recognised for external comparisons. As a result, the NHS appeared to be doing very well compared to other systems on measures such as length of stay and activity. As Smee says:

So when ministers asked how we were doing, given our low level of expenditure, the efficiency measures were misleading, and the health outcome measures weren't there. But the health status measures that we did have looked all right. We were solidly in the middle of the OECD [Organization for Economic Cooperation and Development] road on a lower level of expenditure.²⁴

As late as 1994, he notes, in its annual economic survey the OECD was still rating the NHS as “a remarkably cost effective institution”. By the early 1990s, the first proper health outcomes measures in the form of five-year survival rates for cancer began to emerge, to be followed by others. The NHS turned out not to score well. Furthermore, he says:

For a long time, no one really seemed to ask why, if we were so efficient, we still had waiting lists and we were not getting them down. People were inclined to dismiss them as something you had to put up with. Economists tended to say that waiting was a better way of rationing care than price – as if that was the only alternative. It only gradually dawned on people that in most other European countries where hospital care is also effectively free at the point of use, they did not have these awful waiting times. To be sure, they spent more. But then we appeared to be so much more efficient. Yet we still settled for these long waits. It was hugely inward-looking and complacent, really. A refusal to believe that we had all that much to learn from other countries.

By 2000, the OECD had sharply changed its tune. That year's economic survey noted poor cancer survival rates, suggested that other disease-specific outcomes were also poor, highlighted long waits and the apparent under-investment in doctors and buildings – and concluded that the NHS was probably underfunded. It was broadly that analysis which Derek Wanless delivered in spades, when commissioned by Gordon Brown to provide the justification for the huge spending increase that Tony Blair had already promised: to get the UK's health spending up to the European average. Wanless pointed out that, compared to the average of other western European countries,

24. This passage is drawn from a combination of interview and Smee C. *Speaking Truth to Power: Two Decades of Analysis in the Department of Health*. London: The Nuffield Trust, 2005.

the UK had underspent by a cumulative £220 billion between 1972 and 1998. On that basis, it was hardly surprising if the NHS was struggling, however efficient it might or might not be.²⁵ The big question now, of course, is: what has the recent huge surge in spending actually bought – and what is the future?

Adair Turner, the former Confederation of British Industry (CBI) chief and economist who now heads the Financial Services Authority, and who acted as an unpaid adviser on health to Tony Blair in the early 1990s, is not alone in thinking that too much was spent too fast. He says that it would have been better, for example, to provide seven years of 5% real growth rather than five years of 7%, because the NHS proved not to be capable of absorbing that rate of increase. Unsurprisingly, the result of huge amounts of money pouring into a capacity-constrained system was inflation, not least in doctors' salaries.²⁶ The money has brought an increase in patient satisfaction, improvements in outcomes and now, finally, an appreciable fall in the average wait for treatment – but according to many people's view, not yet enough of any of these things.

So, a key question is whether the big increase has been blown: 'Is that all?', so to speak. Or will the mere fact that spending is now at a much higher base, and still growing, allow greater gains to be made in the coming years? Sheila Leatherman's

carefully qualified view is that it should. The data on outcomes, by definition, are not up-to-date: on at least one key measure – the reduction in deaths amenable to healthcare – the UK made appreciably faster progress than Australia, Canada, France and Germany in the six years to 2003 (the latest year for which figures are available). While catching these countries up on this score, it still lags well behind them, but it has overtaken the USA. "It remains possible that the the NHS is catching up," Professor Leatherman says, "I do think there is some momentum here." Equally, Adair Turner argues: "The money is there and it ought to gradually, over time, buy more." Working off a higher base "must buy some long-term benefit". As they say, we shall see.

However, even if there are further gains to be had, is the NHS sustainable? There are plenty of prophets of doom, although it is important to understand that the question can be asked equally about health systems in all the western democracies. Are any of them sustainable?

Nicolaus Henke, head of McKinsey's health practice in London, has looked back with colleagues over nearly 50 years of health spending by all OECD countries and came to the conclusion that over that period it has outgrown consistently the rise in national income, or GDP, by two percentage points a year. The consistency of the trend is, he says, "startling". Countries

25. Wanless D. *Securing Our Future Health: Taking a Long-Term View*. London: HM Treasury, 2002.

26. Interview with Baron Turner of Eccchinswell, p.169.



“By 2050 most countries will spend more than 20% of GDP on healthcare, and the US will be spending well over 30%. By 2080, Switzerland and the US will devote more than half of their GDP to healthcare, the position most other countries will reach by 2100. By then the US would be spending 97% of its GDP on healthcare and the UK 63% – almost two-thirds.”

Nicolaus Henke

occasionally manage to roll the rate of increase back, but it soon reasserts itself. If it continues,

by 2050 most countries will spend more than 20% of GDP on healthcare, and the US will be spending well over 30%. By 2080, Switzerland and the US will devote more than half of their GDP to healthcare, the position most other countries will reach by 2100. By then the US would be spending 97% of its GDP on healthcare and the UK 63% – almost two-thirds.

That is difficult to conceive. But in 1960 most observers would have said that 40 years on it was pretty inconceivable that western Europe

on average would be spending 9% of GDP. But that prediction, of course, has come true.²⁷

At least for a time, he points out, it is not a problem if health takes a larger share of GDP as countries get richer:

The most convincing correlation in the whole of social science is the one which shows that the richer a country, the greater the share of national income per head it spends on health, whether publicly or privately. So beyond a basic minimum, health is in fact a discretionary good.

And if an economy is growing, a larger share of a larger cake still leaves more actual money

27. This passage is drawn from a combination of interview and Henke N. et al. The Healthcare Century, McKinsey and Company 2008. *Health International*: 7(May) 6.

“The most convincing correlation in the whole of social science is the one which shows that the richer a country, the greater the share of national income per head it spends on health, whether publicly or privately. So beyond a basic minimum, health is in fact a discretionary good.

And if an economy is growing, a larger share of a larger cake still leaves more actual money to be spent on other things. So health can probably continue to take a larger share of GDP for a while; but it remains hard to conceive that countries or individuals will allow it to get to 50% of GDP.”

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to be spent on other things. So health can probably continue to take a larger share of GDP for a while; but it remains hard to conceive that countries or individuals will allow it to get to 50% of GDP.

It is possible, he says, that technology – which generally is seen to increase costs in healthcare, even though it lowers them in most other sectors of the economy – may surprise everyone by producing productivity gains that will come to the

rescue. Big behavioural shifts might also change the picture. Twenty-five years ago, he points out, the number of countries that have gone, or are going, smoke-free in public places would have been unimaginable. So, “if social norms were to shift dramatically so that overeating and under-exercising became truly abhorrent, demand for healthcare could fall”.

However, in the absence of those, and/or of various payment mechanisms and incentives

reining in demand, there are three likely options that will prevent healthcare costs taking half of all national income. First, younger people may balk at paying for older people's health costs which, after all, are the biggest demand on the system. Second, competition for public funds from other sectors – notably social care and pensions in ageing western democracies, but also education and other spending areas – may force a limit on health spending. Alternatively, the return for each extra marginal dollar spent on health may decline, reducing the incentive to spend more, whether publicly or privately.

Of course, one always should be a little wary of allowing management consultants to define the problem. They don't get paid for saying that there isn't one – and they are always hoping you will hire them to fix it once they have identified it.

Recently, Jonathan Anscombe, head of A.T. Kearney's European health practice, has argued that (like it or not) *all* healthcare systems will be driven to a common model by the combined pressures of technology, ageing and rising expectations. These between them will create

a perfect storm that will expose the real limits of taxation-based healthcare funding [a definition that includes social insurance models]. Most European systems currently, or will soon, face economic crises. They are not

alone. By 2050 China will have the same age profile that Europe has today.

The result, he argues, is that all governments – whether the UK, the USA, any of the continental Europe models and those in emerging countries – will be forced to define the core services available to all.²⁸ These will concentrate on vaccination, screening and prevention – measures aimed at lower long-term costs – along with emergency and trauma care and support for disadvantaged groups. Increasingly, payers (public or private) will specify how care will be provided, and “a plethora of private, insurance-based services will focus on faster access and expensive, marginally cost-effective, and lifestyle therapies”. Primary and emergency care, where competition is not effective, will become state-planned, nationally or regionally. Citizens will make higher co-payments, and they will have to meet the costs of non-core services. Countries may not want this, Anscombe argues, but it is inevitable – and “it is hard to see how this can be achieved without making care more unequal”.

Perhaps unsurprisingly, this cataclysmic view is not one that appeals to the former health secretaries interviewed for this publication. Clarke and Milburn – who must rate along with Bevan, Powell and Castle as the five political giants of the NHS's 60-year history – maintain that history is against the argument.

28. Healthcare Out of Balance. A.T. Kearney's Executive Agenda 2008; XI (1): 44–53.

“Most European systems currently, or will soon, face economic crises. They are not alone. By 2050 China will have the same age profile that Europe has today.”

Jonathan Anscombe

As Clarke says:

If you look back over the 40 years, I think the case [that technology, ageing and expectations will overwhelm the service] has been belied, because it has continued to improve and advance. And it's never been sensible to compromise the principles of free at the point of delivery, paid for out of general taxation.

Milburn says: “If you think about it, in each successive decade you've had the advent of a new technology or treatment that was going to break the bank.” However, technology, he says, is “a double-edged sword” that can save money as well as cost it.

Stephen Dorrell²⁹ points out that the Guillebaud report in 1956 first outlined the pressures of technological advance, demographic change and rising expectations. Yet this service has adapted and survived, and he sees nothing that has altered, qualitatively or quantitatively, to change that.

Certainly, some of the Conservative politicians, and some former chief executives and permanent secretaries, do believe that an element of top-up or co-payment is likely, inevitable or even in some cases, desirable. For example, the UK is increasingly distinctive in having no co-payment for a family doctor visit.

Even Alan Milburn concedes that in time there may be a case for allowing a small element of top-up payment for technologies that are effective at the margins, but which the National Institute for Health and Clinical Excellence (NICE) judges not to be cost-effective:

But even if the flexibility at the margins happened, that doesn't alter the central case which is that, for the vast majority of patients, the vast majority of time, for the vast majority of treatments and in the vast majority of cases, people get their care on the NHS. That is what happens.

Indeed, when asked to list the NHS's greatest achievements, all the politicians, Conservative or

29. Secretary of State for Health, 1995–97.

Labour, delivered their own version of Bevan's famous phrase: that the creation of the NHS "lifted the shadow of fear from millions of homes". That its universal availability, largely without charge, has been its greatest strength. None could see – on the time horizon to which politicians operate – the political circumstances that would change it.

Some, particularly but not only the Labour politicians, went further in defining the service's strengths. Frank Dobson said its greatest characteristic is that it is "the most popular institution in the country... so that besides binding the nation's wounds, it actually helps bind the nation together, at a time when most of the forces working in society are fragmentary". Patricia Hewitt made a similar point, while Milburn says, "in a world which is becoming increasingly atomised, it is part of the glue, the social glue that holds Britain together".

When asked about the NHS's weaknesses, despite their trade, almost all of the politicians identified politicisation. All regretted this and the short-term nature it brought to debates about the service. As Kenneth Clarke said:

It's hopelessly over-politicised and lives in an air of constant controversy, although I think that's inevitable with healthcare systems. In my opinion, in every western democracy, the public

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Kenneth Clarke

believe they live in a crisis. But in our case it is always in danger of being dominated by the domestic political controversies of the day. We seem to go in for a little flood every now and again, of: 'Can the system work?' – which I think it can – but it does undermine confidence in the service all the time, and it brings unnecessary degrees of partisan controversy into everything.

Milburn says the scale of political involvement means

the temptation as the health minister is always to nationalise responsibility, rather than to devolve it – even though you know that you shouldn't be nationalising. Because the pressure – media, public, patient, professional – is to get something done: 'Go and sort it out.' And the consequence is that you have an accretion of power to the centre.

Even so, the politicians recognised that the politics brought accountability. They were divided – sometimes ferociously, and not just on party lines – about whether an independent board would help. Most felt that it would not; indeed some, including Clarke and Milburn, vigorously opposed it.

Another big weakness that the politicians repeatedly identified – again, across parties – was the service's lack of responsiveness, its failure to be patient-orientated. Stephen Dorrell said that it still has a tendency to say "go away... at its worst, it comes close still to having a sense that it is state charity for which you should be grateful".

According to Milburn, by 1997:

it had not kept pace with the times... it was too concerned with the interests of those providing

the service and too little concerned about those who were using the service. And for all the talk that the uniformity of provision would deliver uniformity of outcome, actually over the course of 50 or more years, over 60 years, inequalities between rich and poor in health terms have got wider, not narrower.

Meanwhile Virginia Bottomley³⁰ recalled with horror a story – admittedly from many years back when her children were young – of watching a nurse deliberately move her child's notes to the back of the pile when she, as the mother, had complained about how long they were waiting.

A further weakness (and one not often discussed) that comes roaring out of the contributions to this book – from medics themselves, managers, civil servants and politicians – has been the NHS's failure to engage the medical profession properly in management, particularly in hospitals and now in the commissioning of care. In this, the NHS is not unique. But it is unusual in the degree of failure – and that failure in itself may help to account for the way that the UK has slipped down the health outcomes table. Duncan Nichol, NHS chief executive between 1989 and 1994, said he wholeheartedly agreed with an analysis that went:

If you have an MBA in the States and you're a doctor, people think, well, you're a sharp guy. Here they think, you're a grubby businessman

30. Secretary of State for Health, 1992–95.

and it's beneath you. The medical profession in this country has tended to abdicate its leadership role in management to managers, and then bitch about the result and disengage.

Sir Kenneth Stowe³¹ says that one of the great disappointments of the outcome of Sir Roy Griffiths's management inquiry³² was that it did not produce the big rise that Griffiths believed was necessary in the involvement of doctors in management. The contributions from Graeme Catto, Carol Black and others all recognise the problem. There is room for debate about whose fault it is: the doctors, the managers or the politicians. As Stephen Dorrell says:

Professional independence and accountability was to some extent a casualty of the management reforms of the 1980s and the internal market of the 1990s. That changed the terms within which professionals operated. And when Labour in a large measure reversed that in its earlier years, it replaced the pressures that the market reforms had brought with the imposition of even stricter management control through central targets.

The way back, it seems to me, is to build the professional angle into the commissioning process, so that commissioning should involve the professions rather than be done to the

professions, not least because it is probably the only way to achieve effective commissioning.

Duncan Nichol says:

When we have engaged doctors in designing and leading the strategic development of services, when we've encouraged them to understand the economics of health, when we've encouraged them to develop, as in cancer, risk-adjusted benchmarking, [it has brought] a completely different dimension to the management of care.

There is some hope that this is now changing. Wider publication of measures of the outcome of care, the arrival of foundation hospitals as free-standing businesses, and service line reporting that allows doctors to see the costs and benefits of what they do, finally may be pulling doctors more effectively into management. Nichol is far from alone in seeing this as a change that is "desperately needed".

There is plenty of food for thought on this and other issues in the essays and interviews in this book: whether the market model which the parties seem to accept is capable of delivering the integrated care that patients need; how far changes in accountability would make it easier or harder to configure services in different ways

31. Permanent Secretary of the Department of Health and Social Security, 1981–87.

32. Griffiths R. *NHS Management Inquiry*. London: Department of Health and Social Security, 1983.

“If you have an MBA in the States and you’re a doctor, people think, well, you’re a sharp guy. Here they think you’re a grubby businessman and it’s beneath you. The medical profession in this country has tended to abdicate its leadership role in management to managers, and then bitch about the result and disengage.”

Duncan Nichol

to cope with the growth of chronic disease; how the whole system can be made more accountable to the people it is there for: the patients; and how patients themselves can become producers of their own health and care. Also, whether commissioning ever can be made to work. If it cannot be, Clarke says, “that would be the biggest blunder of them all. If one day subsequent generations find you cannot make commissioning work, then we have been barking up the wrong tree for the last 20 years”.

Money, as ever, lies behind much of this, so one final thought on it. Whether the cataclysmic view of what ageing and technology will do to health systems in the long run is right or wrong, what are

the more immediate pressures that may alter the funding system in the UK?

There are three obvious ones. The first is top-up payments brought about, ironically, by one of the NHS’s great success stories: NICE. NICE is a part of the NHS that other countries envy – and have proved they do so by starting to imitate it. Half of all the hits on NICE’S website come from abroad, its guidance influencing care around the world. However, because it focuses on what payers of all kinds (public or private) are interested in – cost-effectiveness – it begs a question about what happens around technologies that may be effective at the margins, but which come at a price that NICE judges not to be cost-effective.

The pressure for NHS patients to be able to keep their NHS care but pay on top for a certain cancer drug or other technology – rather than having to go entirely private – is already there. Some primary care trusts and hospitals are quietly allowing it to happen already, even though it is against Department of Health policy – and the pressure can only get stronger. The BMA's consultants' conference recently backed the move; the BMA as a whole may do so shortly, and Doctors for Reform plans a judicial review which could see the Department's stance declared illegal. A government review is underway at the time of writing, and the issue looks more to be 'where should the line be drawn?' in allowing top-ups, rather than should they be allowed at all.

If patients are to be allowed to pay on top for exotic cancer drugs, would they also be allowed to pay the difference for a more sophisticated lens implant than the one the NHS is prepared to fund? To some – indeed perhaps to many – that would mark the end of an NHS where patients are treated on the basis of clinical need, not ability to pay.

Although the outcome is not yet clear, it does feel like something of a 1950 moment when Bevan resigned over prescription and dental charges. Yet for all the fact that prescription and dental charges do breach the principle – and for all the mighty row their introduction caused – that hasn't

stopped the NHS remaining overwhelmingly a system where treatment is indeed based on clinical need not ability to pay. What is clear is that the pressure will prove hard to resist – even if some politicians of both parties, ranging from Kenneth Clarke to Frank Dobson, believe firmly that it should be resisted.

Growing pressure to create individual budgets for chronic conditions in health (they already exist for social care) could push in the same direction. For example, if the state gives me a budget to spend on my healthcare, how can it then say that I cannot top it up, and that I have instead to surrender it and go entirely private if I want to add to it?

The second is the arrival of telemedicine and telecare. The boundary between free at the point of use healthcare in the UK, and means-tested social care always has been contentious and blurry. However, when systems are available that allow remote monitoring of heart and lung conditions, diabetes and the like (healthcare) but also check whether someone has got out of bed in the morning and opened the fridge (social care), or fallen (health and social care), the decisions about how this is paid for – again at the margins – will become even tougher.

Third, all three political parties are now committed to a review of social care funding. The range of

possible outcomes is large: from some form of stop-loss insurance by the state, to a reluctant admission that the present system is far from perfect but not as unfair as it is seen currently. However, were the outcome to be on the lines that Derek Wanless suggested in his recent King's Fund report³³ – a basic entitlement to care for all, with matching payments beyond that up to a limit, in order to encourage private provision – then this could be the Trojan horse that finally opens up the debate on a core NHS package with top-ups. A decision on a new social care funding system, however, will not get taken until a general election produces a new parliament – if then. Whether Labour or the Conservatives win, both currently remain committed to the existing NHS model, which takes us out to 2014 or so.

So, on its 60th birthday, the NHS should probably recognise itself for what it is: a service with great strengths as well as some marked weaknesses. One that rates high in terms of outcomes and equity in the world league table of healthcare, although overall only in the middle of the pack on outcomes among developed western nations: good on some things, decidedly bad on others. A system that is, undeniably, getting better. One whose citizens least feel that it is in need of major reform compared to those in Australia, Canada, New Zealand, the Netherlands and the USA, according to a Commonwealth Fund study.³⁴ It should recognise, in Milburn's words,

“When we have engaged doctors in designing and leading the strategic development of services... [it has brought] a completely different dimension to the management of care.”

Duncan Nichol

that it is “a very particular, peculiar even, system of healthcare”, and in Clarke's, that “the fact that it survives by a kind of miracle is one of its endearing British features.” It should enjoy its birthday while acknowledging – as Bevan did – that, like other health systems, it will always be inadequate: that it needs to improve and some aspects of it badly need to change.

Also, perhaps it should stop doing what it has done for much of the past 60 years: performing better, while feeling worse about it.

33. Wanless D., Appleby J., Harrison A., Patel D. *Our Future Health Secured? A Review of NHS Funding and Performance*. London: The King's Fund, 2007.

34. The Commonwealth Fund. *Commonwealth Fund International Policy Survey*. Available at: <http://www.commonwealthfund.org>.



CHAPTER 1: "THE GREATEST EXPERIMENT"

– POLITICIANS



Lord Patrick Jenkin

Lord Patrick Jenkin, Baron Jenkin of Roding, is President of the Foundation for Science and Technology. He was Secretary of State for Social Services from 1979–81.

The principle that treatment should be free at the point of use is, without any doubt, the single distinguishing characteristic of the NHS. It doesn't depend in any sense on a contribution record. [Aneurin] Bevan saw that as the biggest achievement of the Attlee government.

The biggest weakness is that it has been conceived and run throughout as a top-down operation with everything determined from the top, run from the top with people who actually deliver the care at the grass roots level having to follow increasingly complex directives and changes of organisation. But if you have the NHS paid for centrally out of taxation, you cannot put the patient or the doctor in charge. It has to be the Secretary of State who negotiates with the Treasury for the total sum of money at its disposal.

When I was in Opposition, shadowing the Department, which was 1976–79, I got together a collection of advisers and tried to answer the question: 'Could there be a different structure which would put both the local deliverers of healthcare and the patient more in the saddle and less beholden to the top-down directives and legislation?' We came to the conclusion the

way to do that was actually through a publicly-provided, publicly-administered health insurance, which provides the money which is necessary to pay for the treatment. This is, of course, is the pattern that is followed by most other countries in Europe.

When we got into government in 1979, Margaret [Thatcher] appointed me to do the job that I'd been shadowing for three years. I fed the papers into the Department [of Health], and said, "If we're going down this road, what is the route to get there?" We never solved that one. One or two of the doctors and senior officials were really quite sympathetic, but the great weight of the Department, including Pat Nairne,¹ never really bought it. There was never any publicity, because at that stage it was an extremely sensitive political argument. There was nothing in the manifesto about it, and nor could there have been. I doubt whether Margaret would have welcomed it – she was extremely cautious in 1979. When I got into the Department of Industry and started to privatise British Telecom – that was the first big privatisation of a major state industry – and even then I had to persuade her. She never bought [the idea of privatising] the Post Office. "Oh, no, it's the Royal Mail, we can't touch that!" And look at the problems now, business deserting it in droves.

People don't realise that in other countries they can get a very much better service. It is very good

1. Permanent Secretary at the Department of Health and Social Security, 1975–81.

here if you're extremely ill, but now increasingly we're finding that the care of the very old and long-term services, particularly mental health and long-term disability, are the Achilles heels of the health service, and always will be. They don't command the same political importance that Accident & Emergency [A&E], or an acute hospital do.

I was for six years chairman of the Forest Healthcare Trust, which ran acute and long-term services at Whipps Cross Hospital. We had half a dozen superb consultants who were pointing the way in their own particular specialties. That was what sustained the reputation of Whipps Cross, giving us university associate status, which again was very valuable, particularly in training junior doctors. We were in an area where it was not difficult to recruit nursing and other ancillary staff, but it was sometimes quite depressing to see that there wasn't a lot of pride; public service was seen as a job, like any other job. I don't know whether that is inevitable, whether it's a matter of leadership, whether there are places that could lead and inspire people in a very much better way. Somehow that's what much of the NHS lacks.

There's a very widespread feeling, both within politics and out there in the field, that the NHS could certainly soldier on for some time yet. Whether in fact in the end it will be the long-term care of the elderly, the mentally ill or mentally

disabled which will force the revision, is something which I'm not in a position to foresee. I don't detect any wish on the part of David Cameron² and his colleagues to want to make major changes. He's nailed his flags very firmly to the NHS mast, and it would be an extremely difficult sell at this stage to say, "Well, actually we've come to the conclusion it's not sustainable and we've got to change."

I collapsed here [in the Palace of Westminster] some few years ago, and was carried out on a stretcher, unconscious to St Thomas's [Hospital] over the road. I then got out of A&E and went up to a ward, and said to the physician in charge, "Look, I've got a BUPA subscription, I find the noises from the other beds rather trying." I was up on the top floor within an hour overlooking the terrace of the Palace of Westminster – that was quite funny, but very nice. And when I had open-heart surgery for a leaking valve, I arranged to go to Papworth [Hospital] and was treated in a private ward there. From the point of view of the surgery and the nursing, I had probably much the same as an NHS patient, but I did have a room to myself. My family could visit whenever they wanted to. So from the point of view of getting something a bit better, and in some cases of course, getting it earlier than you otherwise would, then there is an advantage in private care – but should there be? As one of our spokesmen downstairs said the other day in the Archbishop's debate, equality is

2. Current Conservative Party leader.

not one of the objectives that the Conservatives have closest to its heart, we believe in opportunity; and I have always felt that if people could pay for the extras, why shouldn't they?

When the White Paper *Patients First* was published,³ a delegation of health service trade union leaders came to me and said: "We want to change the title. We always put patients first!", and I said, "Well, it didn't look like that during the Winter of Discontent." They were still picketing hospitals to keep the heating oil out. I had to go to a trade union meeting on social security, to talk about pensions – a speech I cleared beforehand with Margaret [Thatcher]. Len Murray was there, the General Secretary of the TUC. I said, "Before I talk about social security, I am going to talk to you about the National Health Service and what is going on there at the moment." I gave them the most terrible rocket, and Len Murray tried weakly to defend it. The next day the *Guardian* had a marvellous leader, absolutely backing me and condemning Murray for even having attempted to try to defend what was going on.

When I opened Ealing Hospital I had the trade unionists bellowing through the windows, to try to drown out what I was saying in the course of my opening speech; they were dreadful. We were one of the beneficiaries of the general policy of bringing this whole system of labour relations under a much clearer, firmer control.

Then there was the case of Lambeth, Southwark and Lewisham Area Health Authority, which refused to abide by a cash limit. They actually took a resolution that they were not going to cut services to patients. That was the trigger – without any hesitation I sacked them and put in commissioners, which was applauded by almost all the press. One of the hospitals that they were going to have to close was in Bermondsey, and poor old Bob Mellish⁴ was in tears in my office. I felt very sorry for him, but he didn't really try to say that I shouldn't have done it; he was just trying to make sure that I understood how awful it was.

Of course there was a frightful fuss from the Opposition, and we had to enact legislation through the House to validate what I had done. Although Stan Orme⁵ and his colleagues in the Labour Party were very cross about it, they didn't vote against it; and of course, universally in the rest of the health service, they said it just had to be done, otherwise all discipline would have disappeared. There's never been any attempt to break the cash limits by the health service since. The only attempt was by local government, and that's why we had to cap them all.

When later on I was faced with the Militant Tendency in Liverpool, there was the prospect that I might have to put in commissioners to run the city. I had nightmares of crowds 100,000-strong all around rioting, and smashing things up. It never

3. Department of Health and Social Security and Welsh Office. *Patients First*. London: Department of Health, 1979.

4. Labour Chief Whip, 1969–76 and MP for Bermondsey at the time.

5. Shadow Health and Social Security Spokesman during Jenkin's tenure as Secretary of State for Health.

came to that. Somebody asked me the other day, "Who won? Was it you or Derek Hatton?" And I said, "Well, I'm not in a position to say that." I got my legislation, I made it apply to the Liverpool City Council, they complied with it, and they never tried to do it again. Derek Hatton? Well, he's on the 'rubber chicken' circuit.

I don't think at the moment that we could go back to pre-1948, and have the health services back under local authority control. They're not geared up to do it at all, it would simply bring back the National Health Service in another guise. Whether over the period of years, that would change, become more responsive, I don't know. I just don't regard that as a practical possibility.

When I legislated in 1979–80 under the White Paper, *Patients First*, we were looking at a substantial simplification of the top-down structure in the NHS. Remember the headlines, "Prepare to Shed Thy Tiers"? The area health authorities which Keith Joseph had established earlier had simply been based on co-terminosity with local authorities; in health terms, they made no sense at all. We got rid of the area health authorities and a couple of other tiers, and ended up with district health authorities. I was very much wanting these authorities with their medical committees to determine what the service was going to be in their area and their priorities. This is where I've had exchanges with our health people

"You've got to cope with something that I never had to cope with, that's postcode prescribing. If you're going to have devolution, when people say, 'Isn't it terrible, you get it over in the next county but you can't get it here,' you've got to be prepared to face up to the argument and say, 'I'm sorry, it's not our highest priority.'"

Patrick Jenkin

now in Opposition, who very much want to pursue the same devolution of responsibility. I said:

You've got to cope with something that I never had to cope with, that's postcode prescribing. If you're going to have devolution, when people say, "Isn't it terrible, you get it over in the next

county but you can't get it here," you've got to be prepared to face up to the argument and say, "I'm sorry, it's not our highest priority."

The other question was: did we need regional health authorities? In Opposition in 1979, Pat Nairne pleaded with me, saying, "Don't make any announcements about regional health authorities until you've really had the experience of knowing how they work and what they do; they are your only handle on the health service." There were 12 regional health authorities and 12 regional health chairmen, with whom I had meetings from time to time. You issue circulars and you don't know what the effect of that is going to be. The regional chairmen were the levers that I could pull to make sure that something happened.

It was an endless process of reform, which again, has been one of the weaknesses. When in doubt, reform! Hugely unsettling to staff. Another one has just arrived on my desk this morning: *Our NHS, Our Future. NHS Next Stage Review Leading to Local Change*.⁶ It's a 'Dear Colleague' letter from Ara Darzi. When you get that onto the desk of a hospital chief executive, and his or her colleagues, their hearts sink. "What? Not another one. Oh, God, we haven't settled down from the last one yet!" If I had a single message for the people running the health service, it would be: "For God's sake, leave it alone and let them get on with it." This is very much part of Cameron's

approach: trust the professions of doctors and nurses, they know what they want to do. Let them get on with it. Make sure they have the resources, but don't go on messing them about all the time. And that will be a very popular message.

6. Department of Health. *Our NHS, Our Future. NHS Next Stage Review. Leading Local Change*. London: TSO, 2008.

Lord Norman Fowler

Lord Norman Fowler, Baron Fowler of Sutton Coldfield, was Secretary of State for Social Services from 1981–87.

The NHS's greatest strength is that it provides healthcare irrespective of income and on a basis of need. There are criticisms of it, but it provides an assurance for the public which I think they appreciate. There is overwhelming support for the idea of a National Health Service in the way that we organise it: tax-funded, largely free at the point of use and accessible to anyone who is in need. That's not to say that there aren't queues but the obvious point – if you have a serious health problem, you're going to get treated, and that assurance is fundamentally important to millions of people.

Its greatest weakness is still its management, and – though I don't like using the word – its bureaucracy. It is sometimes not as user-friendly, as consumer-friendly, as it should be. It is a question of management, and the best-managed organisations do manage not only to get efficiency, but also to get the staff enthused with the idea that they are serving personally the user. There's still a slight kind of feeling that we're doing you a favour, and that "We know best, and that you'll take your turn and kindly don't complain – and if you want a prescription, you're going to have to blooming well have to come in and get it!" That, it seems to me, is the worst

thing about the health service. But there is still a very strong basic support for the health service, and I think that people, under all governments, exaggerate the public discontent.

I set up Roy Griffiths¹ and his investigation, which I think was an extremely good one. It's extraordinary that we were 40 years into the health service and we hadn't got to the point of addressing the management issues properly. Even great people like Keith Joseph would talk approvingly of consensus management, which was so obviously inadequate – consensus management was basically a way of avoiding decisions. This is the biggest organisation in Britain to run and the idea that you can run it without proper managers is totally misjudged and misguided.

Even today the good managers of the health service need much more support than they get. It always frustrates me that on both sides of the political spectrum, the easiest way of getting a cheer is to say there are too many managers. I don't think there are too many managers. There may be not enough good managers.

By the end – and I was there for a long period at the Department of Health – I was basically in favour of a National Health Service Commission, and that would have been one step away from the health department. The Department of Health had some extremely good advisers in it but the

1. Author of the Griffiths inquiry into NHS management and at that time (1983), managing director of Sainsbury's.

management knowledge, the direct experience of running and managing big organisations, was not actually a skill that the Health department had. A health commission with a separate board, separate chairman, separate chief executive but with power, would have been the right way forward. I remember putting this once in conversation to Margaret Thatcher, and she thought about it and said, “No, I don’t think we can do that, they’ll say we’re just doing this as a prelude to privatising.” And that, regrettably, is exactly what they would have said. I’m interested now to see that 10 or 15 years later, it tends to be something that the Left of politics actually puts forward, as opposed to the Right.

I hope it could successfully take some of the day-to-day politics and the day-to-day ministerial involvement out. It’s certainly never going to be politically problem-free because there are issues which come up which are obviously profoundly important, and there’s no way round that. But if you ask me, what is the best way of running an organisation as massive and as complicated as the health service, I would not say that it was to have all the strands going back to the health department. It would be much better to have it run as you would run any other big organisation, but with that organisation being responsible to the minister.

There were some successes in the public sector.

I know it’s a very controversial thing to say, but the BBC is a success. They’ve just slightly messed up the organisation at the top in the last year or so, but for the last 30, 40 years it has been a very successful organisation. There’s no reason why there can’t be a successful publicly-owned organisation.

I have absolutely no doubt that a National Health Service will be here in 10, 20 years – David Cameron and Andrew Lansley² have made that absolutely clear. The health service remains the mainstay of health in this country and we’ve now, as much as we ever can, reached some sort of consensus in this area. I can’t see any government, in the next decade (and probably much more) thinking that somehow changing the financing of the health service is going to be some glorious panacea, that with one bound we’re free from all the pressures of demand and healthcare. I just don’t see it. Indeed, I would claim that we are probably the most cost-effective of the health services in the western world.

There has always been a sort of either/or argument about health in this country; you either have a public health service or you have a private health service. I’ve always taken the view that you can have the health service as we have it organised at the moment, and a private sector that can operate side-by-side and make contributions to the health service as well.

2. Current Conservative health spokesperson.

Part of the pressure originally for the private sector was that people wanted a room for themselves: it had nothing to do with the medicines they get or, indeed, the kind of care that they get; they just wanted a bit of privacy. I don't think that you can actually say, because you can't provide a private room for everybody, you therefore shouldn't provide it for anybody. You may well get to a situation where some of the extra facilities have to be, or may be, provided by additional insurance, but I still don't think that invalidates the model. It's going to make it more difficult to manage, to run, and the public perception is going to be quite difficult, but I still don't see that there's another model just round the corner.

There was the review of alternative finance for healthcare carried out by the central policy review staff at No. 10 in 1982. It's not possible, in my view, to have a Secretary of State working on health and then another group, not only working away on plans of their own but also, inconveniently, making those plans half-baked – which then managed to get into the public domain. So you had a political problem. Obviously, I had to put these things to the Cabinet, but there was almost no disagreeing with my view that we should simply reject them. From memory, Margaret [Thatcher] was entirely in support of that, but so were others as well. The Treasury would have liked to have continued. I think it was Quintin Hogg who said that when he saw it,

“My hair stood on end, and at my age that takes some doing.” I thought the political fallout of all this was disastrous and wasn't going to lead us anywhere.

I'm not in favour of a change of funding for the NHS. What you've got to avoid is leaving a whole range of people without the assurance that they will be given good healthcare, and unless you're careful, you'll get into all the exemptions and rules of social security, and to go down that road again is, frankly, not attractive.

I think the biggest failure of the health service at the moment is public health. One thing we did manage to establish at the end of the 1980s was that if you put a major effort into public health, which we did with HIV/AIDS, you could have a real impact. People still argue about whether it was the right message, but there was no question that it was a campaign which had impact. The health service and the Department of Health responded magnificently. We established that the public listened to the objective advice of the health department, and the health service could communicate directly with the public and the public would follow their advice. We didn't spend fantastic amounts of money; it was significant, I think it was over £20, £30 million. The worst thing would have been had we done nothing, like the Americans.

Yet the tragedy has been that since then, we have just gone off the air on this, particularly in this area, which has got worse – AIDS and HIV and sexual disease generally. Sexual disease – the figures there for almost everything have increased vastly since about 1996. The government say, “We believe in devolving all these decisions to PCTs [primary care trusts].” I am in favour of devolving, but to think that you can devolve all of public health to the PCTs is ridiculous. At the end of the day, if you do a league table of popularity for the areas which the public feel you should spend money on, sexual health, HIV/AIDS, all that, will come bottom of the list.

Certainly, we want devolution in some areas, but to have it in all areas is crazy. It’s like devolving sewerage to each local authority to have their own specific policy on that; it doesn’t make sense. No one in industry would run an organisation in that way. Public health is not given the priority it should have, and that is partly because the government and the Department don’t accept the responsibility for it, and so it won’t get done. There will be some who are saying it’s the ‘nanny state’. On the other hand, there will be quite a lot who are quite sympathetic to that.

The most interesting thing about this Labour government is that, basically, they have continued on with the kind of things that Ken and I were setting out, which was belief in the National

Health Service, but also that you could have a developing private sector on the supply-side. Rather than there being the sort of apartheid in health, the idea that both can work together is something that the Blair government took on. When we were arguing for this in the 1980s, Labour were ferociously opposed to it at every stage.

It is impossible to tell where the balance should end up. You can always argue about the boundary, but the most important part is that all the parties more or less are signed up to the same approach.

My memory of the 1980s is that every change we made we had to fight through, and often with really bloody battles. I remember general managers – that was regarded as bringing in supermarket techniques. Contracting out, we had to fight through. We introduced the limited list of drugs and that was a massive row not just with the unions but with the BMA [British Medical Association]! They said that we were interfering with their right to prescribe and choose, and goodness knows what. I’ve not noticed any government since actually going back on any of these policies. The idea that doctors could today prescribe the kind of drugs that they are prescribing back in the 1980s, I think, is ridiculous. The 1980s were quite a pivotal time because we went through a major health strike in 1982, the

time of the Falklands [War]. It was a time of battle after battle to do anything – even to count the numbers that the NHS employed was regarded as revolutionary. It didn't matter how self-evident a change was, it took months of preparation and then months of battling to get it through. Demonstration after demonstration. Every time I went to a hospital the question was not, "Is there going to be a demonstration?", it was, "How big, and where are they?"

It's extremely healthy that that position has now changed, but it needed the 1980s to change it. The extent that one can get some kind of agreement, in broad terms, on the way ahead – that's very much in the interests of the health service. [The idea of] a Health Service Commission wouldn't be as controversial now as it might have been in the 1980s.

If there was a new Conservative government in a couple of years' time, I don't think that the new health secretary would have any of the problems that I and Patrick Jenkin and Ken Clarke had in the 1980s.



Rt Hon. Kenneth Clarke

The Rt Hon. Kenneth Clarke is the Conservative Member of Parliament for Rushcliffe. He was Secretary of State for Health from 1988–90 and Minister for Health at the Department of Health and Social Security from 1982–85.

Should we be celebrating the NHS at 60? Well, yes. I share the general public view. It's a great national institution. It's one of the better healthcare systems in the world, and the fact that it survives by a kind of miracle is just one of its endearing British features. It is a kind of miracle because the pressures on it, as with all healthcare systems, are almost impossible. It is not only rising demands and huge clinical and pharmaceutical breakthroughs – stimulating ever more demand, because you can do so much more – but rising public expectations. People now judge it in the same way they judge every other public and private service that is important to them. They expect a high level of consumer satisfaction from it. When I first encountered the health service, patients were more long-suffering and deferential. Its greatest strength has been the fact that it has spread the highest level of healthcare across the whole population.

I have to hesitate before someone criticises me – I am aware how much individual health outcomes are still affected by social circumstances and linked to poverty and so on. But really, compared

to most countries, we have managed to keep up with clinical advances and have spread the highest quality of care across an astonishing range of the population, geographically and socially.

It is, of course, hopelessly over-politicised and lives in an air of constant controversy, although I think that's inevitable with healthcare systems. In my opinion, in every western democracy, the public believe they live in a crisis. The healthcare system provides the most dramatic and emotional content to the political debate in every country. But in our case, it is always in danger of being dominated by the domestic political controversies of the day. The two problems in managing it are that it is so emotionally charged as a political subject, and is seeking to meet infinite demands out of finite resources. It's a constant weakness. We seem to go in for a little flood every now and again, of 'Can the system work?' – which I think it can – but it does undermine confidence in the service all the time, and it brings unnecessary degrees of partisan controversy into everything.

People have been saying for 40 years that the combination of age and technology will finish it off. In fact, if you look back over the 40 years, I think the case has been belied, because it has continued to improve and advance. And it's never been sensible to compromise the principles of free at the point of delivery, paid for out of general taxation.

The health status of the nation has never been better. Amazing advances have been made in the treatment and care of many important problems. But you are facing infinite demand, and still we're conscious of the fact that we need to do better. When I first encountered the health service as a politician, it's amazing to look back and realise how primitive it was, compared to today's system. There are always people in the service who fondly look back to some alleged golden age. But it certainly was not enjoying any golden age in the 1960s, when I was a parliamentary candidate.

There is also a tendency to say everybody else's healthcare system is better than ours, which is also not true. Some bits of other people's service are, for some people, better than ours. I accept the WHO [World Health Organization] tables are the probably the most objective ranking. We don't come top on that. But there aren't many that are that better. The French are better at elective surgery. They don't have waiting lists. But they don't have our system of domiciliary services and care for chronic conditions.

Prevention or cure?

We should avoid extending into areas which the health service has not covered when other arrangements can continue to respond. I have very reactionary views about the amount of money that is now being spent on preventative medicine and

health education. Of course, I accept the common sense of the messages. But why are we now spending hundreds of millions of pounds telling people to eat a balanced diet?

It is pure semantics to say it's a health service, not a sickness service. The highest priority is the care and treatment of people suffering illness and disease. A bit of health education is all right, but I get appalled by the hundreds of millions for that out of the health service budget, put into sheer campaigning. And look at Scotland providing social care for the elderly without any kind of means testing. The Welsh, and I think now the Scots, are reverting to free prescription charges. This is sheer extravagance which appears to be based on the notion that somehow the mainstream health service is no longer short of resources. The mainstream health service could use all those resources better! I am conscious of the fact that they are unfashionable views, and might actually be classed as reactionary. But that is giving into political pressures to make things cheap and available without concentrating on the service's main priorities.

Vast sums have gone in over the past decade. But they always do. Even I said when I was in office (I still do) that all developed countries seem destined to devote an increasing proportion of their growing GDP to healthcare, and Britain is no exception. It's not sustainable at the rate of

the last few years. The whole problem is that healthcare has to be affordable by the taxpayer, in our case. It is not unique to our country. They have the same pressures in countries where they rely on private insurance. My experience of every [international] gathering of healthcare politicians and managers is they spend their entire time talking about how to restrain cost – and they never really succeed!

Funding the NHS

Alternative systems do not offer a solution. In the USA, their private insurance system only covers a majority of the population. An extremely significant minority are quite unable to afford it. So they have been forced into the taxpayer topping it up, and the US taxpayer's expenditure on health is greater than our own. I just don't think private insurance is feasible. There is always going to be a large section of the population who simply cannot afford to insure against the costs of modern healthcare, and having a topped-up system produces a clumsy compromise of the kind the Americans have now got.

Much of the rest of Europe has a similar problem, because social insurance loads costs on to employers who are now feeling the pain from that – and none of the main parties want to do that here, in an economy where we want it to be

cheap to create jobs. So I don't think a switch to social insurance will happen here.

One obvious reason is the first party that decided to go for compulsory private insurance or top-up payments would be decimated in the subsequent polls. But actually I think it's undesirable anyway. I think you would sacrifice political support for a worthless alternative. I happen to disagree with the alternative models. I don't think they are intrinsically preferable to our own.

The problem with pure market solutions is there is no limit to the money which anybody will try to spend for what they believe to be better healthcare. There is no point in resisting that. You just allow people to go into private healthcare insurance if they want. You get into complications where people want to top up within the National Health Service – for example, the current argument that people should be allowed within the NHS to pay on top for a drug that NICE [National Institute for Health and Clinical Excellence] rejects on grounds of cost-effectiveness.

The danger there, I think, is if you allowed that, within 10 or 20 years you would find we have drifted into a situation where most people would be being induced to top up by salesmen for commercial reasons. Either a treatment is cost-effective, or it is not. NICE is in the better

position to make a judgement about that than the individual patients hounded by fears of the condition that they are suffering from. It is a kind of consumer protection thing, in my opinion, that we don't allow people to top up. That is a better argument than the one the Government insists on using, that the rich should not get better treatment than the poor.

However, the private sector does indeed have a role as a valuable source of competition – on both outcomes and consumer satisfaction. It cuts both ways. The only thing that constrains the cost of private care in this country is the availability of the NHS. When I was in office, I used to point out to Bupa that they were less successful in controlling costs than we [the NHS] were – because once insured, people think there is no limit to what the insurer should pay.

The role of private medicine

Obviously as a Conservative, I'm far more comfortable about having private medicine thrive alongside the NHS. And most past attempts to police that by Labour secretaries of state have led to a certain amount of disaster. But if it starts to soar away, then you should take messages for the health service from that – and you should react. What worries me in education is, I do think the growth in private education – which is quite

strong at the moment, despite the rising costs – is a worrying sign of lack of confidence in the state education system. We have almost reached a stage where almost anybody who can afford private education now does it. That has not happened yet with the NHS. And I hope it does not.

It is a tribute to the health service that it hasn't. In the late 1980s I used to unnerve people sometimes by referring to the private sector as 'our competitors'. That was the way I looked at them. But that was not with a view to putting legal constraints on them or wiping them out – that is just not possible.

As supplier to the health service, the relationship has moved on astonishingly. Labour secretaries of state have got away with introducing private-sector providers into the NHS on a scale which would have led the Labour Party onto the streets in demonstrations if a Conservative government had ever tried it. In the late 1980s I would have said it is politically impossible to do what we are now doing.

I strongly approve of it, but I cannot help being astonished. It's a Labour government, in name at least, which has presided over this tremendous move – although one of the big questions at the moment is: is Brown as receptive to this as Blair was?

Although I began by saying the biggest problem with the service is its politicisation, there is no doubt that healthcare is one of the areas where the political dividing lines have moved very significantly in the last 20 years. It makes the NHS as a system more secure, because there is near consensus again in the way there hasn't been since the 1950s, about the principles upon which the policy should be based. The arguments are very much about competence, and effectiveness and efficiency.

Having said that, I cannot understand all this talk about an NHS constitution again. We have seen all this before: Patrick Jenkin,¹ I think, was the last person who got into argument about a separate, non-political board. It is mainly an attempt by politicians to escape from the controversy that they find they are all surrounded by. Some politicians' first reaction is to say, "Well, let's find somebody else who can shoulder the burden of constant criticism and controversy." I think they are fooling themselves if they think they can get away with that. They're just creating more bureaucracy and getting obsessed. I cannot argue against structural change, because I embarked on it in a big scale myself. But it is the wrong kind of structural change to set up great national constitutions.

The good thing politics provides [despite the problems of politicisation in the NHS] is proper

accountability. It does link the provision of care with paying for it. The root of all politics in all subjects is: how much are you going to spend, and how do you share out the burden of paying for it? And how do you hold yourself accountable?

Changes in the NHS

I enjoyed my two spells at Health. It suited my temperament. Fortunately I don't suffer from stress. It was the nearest I ever had to a constantly stressful job, because it was constant combat. One aspect that has vanished, I hope, for good, is the industrial relations problems that pervaded the politics of the 1980s. Every job you went to mainly concerned clashes between you and the trade unions. You were at constant risk of strikes and industrial action, and when you were attempting to get some constructive reforms going, that bedevilled the whole thing. That appears to have gone.

The other thing I think has gone was that I also faced deep-seated resistance to change of any kind. A fear of change; which is not so remarkable, because that was true of British society as a whole, across every subject, in the 1970s and 1980s. We have been a more successful country, economically and in our public services, because we got so much better at achieving some change in response to rapidly

1. Conservative Secretary of State for Social Services, 1979–81.

changing circumstances. I faced a combination of industrial relations militancy combined with deeply conservative (with a small ‘c’) suspicion at any suggestion of change. That’s the overriding recollection I have of the health service, and that atmosphere has not faced the last three or four secretaries of state.

Having said that, I do worry about the new localism. I always vehemently defend myself as a localiser. I am astonished the Department of Health is still as big as it was in my day. It is probably bigger. I always wanted to push day-to-day responsibility for the delivery of care to the NHS Trust and to the GP fundholders – down to the lower levels and away from the Department and the structural health authorities.

That is why I prefer practice-based budgeting, or GP fundholding – to which the Government is merely paying lip service – and why I worry about the conservatism of primary care trusts, who fear getting involved in the row about the decline of some local hospital provision.

Now, in the name of the ‘new localism’ we are back talking about local government and elected management to foundation hospitals, and I think the public are more suspicious of change, and fearful, than people in the service are. The main feature of elected local government is that

it is ferociously resistant to change. Given that everybody in the service accepts we have still got to carry on reconfiguring it – which means you have got to close some hospitals and move services sometimes to new, more modern facilities – it is at the local level you will get the biggest resistance. It does not matter which party controls the local authority. Most local authorities will refuse to close anything, and will react to public demands to protect, to preserve the service in aspic and keep it as it is.

And then there is the lobbying by staff. I am not excessively critical of the staff lobbying in their own interests as well as the patients’, because they are perfectly entitled to lobby for their interest, like everybody else. But they will have a much more powerful effect on the average county council than they will have on the average Secretary of State for Health.

The pattern of care and the priority needs constantly to change, and that applies to the argument about postcode rationing. You are bound to have local variation and you have just got to hope that the best practice will eventually spread. If you don’t have any local variation, you are back in the problem where you have no change.

Looking back

When you ask me to look back and ask if there were things I would have done differently, the answer is: for sure.

I had two stints, one as minister and one as Secretary of State. With Roy Griffiths,² I was introduced to the whole problem of how to get some management and mobility and flexibility into that service. Looking back, I wish I had not been so inexperienced and could have pushed on a bit harder. I had a lot of autonomy as minister, but my introduction to the service was that, within four days, began a strike which became the longest public service strike of the 20th century – later overtaken by [Arthur] Scargill³ – but we took the record then. So it was difficult to push on on the management front.

An important part of that agenda was trying to get doctors more involved in management. One of the fears in the 1980s was that most doctors actually did not work for anybody. There was nobody to tell them what to do and they did not expect to be told what to do. It did not mean that they all skived, although some undoubtedly did. We did have consultants who never met their junior doctors, who never came into the hospital because they were too busy doing their private practice to do their NHS work. We did

have GPs who had a lock-up shop, who only turned up three evenings a week and went back to live in leafy Essex. We also had doctors who were workaholics and were working themselves into an early grave. The majority were probably overworked and under pressure. But they were desperately fearful, as Nye Bevan found, of being really accountable to anybody for what they decided to do.

One of my first introductions to the service was that I had to go to close a maternity unit in Clement Freud's constituency, and found that Gillian Shepherd⁴ was chair of the Regional Health Authority.

A great demonstration took place, and they were moving the babies inside to try to give me the impression that there were more there than there were. I met the local grand consultants, the obstetricians, who told me ferociously – addressing a minister of state in an absolutely James Robertson Justice way – that I had got to close this place. And they had all agreed they were not going to accept any more referrals to it. “It was dangerous!”, and they had a better facility in some local East Anglian town.

So I said, “Come out with me and say that to all these women and these television cameras outside, who are waving babies at me.” And they

2. Griffiths R. *NHS Management Inquiry Report*, London: DHSS, 1983.

3. The miners' strike of 1984–85.

4. Later Secretary of State for Education in John Major's government.

refused. They absolutely refused. And it turned out they had not shared this opinion with anybody but me and the doctors from whom they were refusing to accept the referrals. One of them said, “That is your job, we are not prepared to do that.” That is a silly story, but it is a true story. It was my first introduction to the fact that some of the medical profession had no time at all for those who did manage the service, but were not prepared to accept the slightest responsibility for managing any change.

Past, present and future

Twenty years ago the vast majority of clinicians despised managers, who were all called administrators. They regarded them as a totally inferior body of people and they would not accept any responsibility on their own part for the allocation or management of resources – apart from, of course, that they used to lobby for the number of beds they could get allocated to their specialty. I think that has changed quite a lot, although it probably hasn’t changed enough yet.

We tried rather crudely to make sure that quite a lot of our new chief executives were doctors. That was not a success. Most doctors want to be doctors, they don’t want to be managers. But there is a way. Clinical responsibility by a practising doctor, who is prepared to contribute to the

management process, is essential. I would like to think there is more than there was. Attitudes have changed. I think doctors are much less conservative (with the small ‘c’) than they were. They may be resigned to fate, some of them, but they do accept that it is all changing a lot.

Although younger doctors still treat everybody with suspicion who is in management or in politics, a much higher proportion are keen, innovative and really want to be allowed to develop their bit of the service as they wish, and are beginning to believe that reform could allow them to do that.

As Secretary of State there are all sorts of detailed things that I just got wrong. I could have minimised the medical opposition to the reforms by abandoning any threat to national pay bargaining. A couple of the presidents at the royal colleges made it clear to me that they would abandon resistance if I restated the principle of national pay bargaining. I had a naive belief that we would begin to get more local flexibility on the pay and conditions of staff if we went down the road I was going [to give NHS trusts freedom to set their own pay and conditions], which has not happened. Gordon Brown shares my views. He once revealed that he was as opposed to national pay bargaining as I am. But what I wanted was not real, in the sense that it didn’t happen, and I do think it added fire to the ferocious resistance I had.

Then there were technical details. Frank Dobson was right when he criticised the cost and bureaucracy of all that individual contracting that we introduced, for which the service simply was not remotely ready. But I did always say that once we pressed the button, we were just starting. There were a lot of unanswered questions to which the answers were going to have to evolve – that was the principle to which I was working.

The best thing the Labour government has done to make the purchaser–provider divide work is to introduce a national tariff. It slightly gets over the problem that half the providers don't know what anything costs, anyway. Purchasing is in such an embryonic state at the moment that there is scarcely anybody capable of negotiating sensibly, contract by contract – and 20 years on we are still in the position where commissioning is the weak point in the whole thing, in my opinion.

PCTs [primary care trusts] are insisting on doing it themselves, and some of them are going to be very bad at it. I prefer practice-based budgeting. But no part of the national machine – the officialdom – is prepared to let go to allow that to happen. I do realise that the weaker parts of general practice will create problems when you do it. But I remain convinced that is where we have got to go. It is a provider-dominated service. If you want a consumer-dominated service, then the purchasing on behalf of the consumer is key. We

have absolutely no residue of skill and confidence to do that. I would be bolder. In the end, every Secretary of State since me who has thought of it has either been put off it, or has allowed his officials to dampen it down and to hold it back.

But I do think commissioning can be made to work. I have already said I am against private healthcare systems. But if you look across other much more private-based healthcare systems, it works – and it is absolutely essential. And it works in private healthcare here. We always say that the same doctors who are worried about it in the National Health Service are accustomed to it day-by-day in their private practice, if they are hospital consultants. In many systems it works. Not, I agree, in the continental ones, because they do not even try. But that would be the biggest blunder of all: if one day, subsequent generations find you cannot make commissioning work – then we have been barking up the wrong tree for the last 20 years.



Lord William Waldegrave

Lord William Waldegrave, Baron Waldegrave of North Hill, was Secretary of State for Health from 1990–92.

It was a long time ago, so you will find me making terrible solecisms – but nowhere else in the advanced world does a minister run the health service, and that encapsulates what’s wrong with it. Because British people are rightly devoted to the concept of universal care, they think – because they have no other experience of universal care, except that provided by this great nationalised industry – that’s the only way to do it. So any attempt to reform it is an attack on universality.

While I am not up-to-date with all the statistics, I don’t think we’re now in the top division of health provision in this country. Other people will have the numbers, but I don’t think our cancer work and our stroke work comes in the top 10 any more. There are treatments available to people in France and Sweden and Germany, and possibly in Spain and Italy – I’m not being specific here – which are not available in this country, and I don’t quite understand why people aren’t more upset.

Well, I think I do understand, because I think they think that the only alternative is a sort of caricature, free-for-all insurance system – and it isn’t. But as soon as you say, ‘The NHS is not as

good as other people’s health systems,’ everyone says, ‘You’re attacking people.’ Of course one’s not doing that – our professionals are just as good as anybody else’s. Our research is probably better. Our professional traditions are probably better, or at least as good, but we’ve somehow trapped people in a structure which isn’t working.

I had huge hopes of Blair. After that initial three years, he did some real good, and with the treatment centres and plurality of care, things were getting really better in some respects. But it all seems to have petered out again, and I have a horrible feeling that the nature of our politics is such that this sort of reform may be something that only the Centre-Left can carry forward.

One of the problems of the political structure here is that all Oppositions go into elections with extremely conservative manifestos. I haven’t seen what my party’s saying, but I would be very surprised if they’re not saying [that] they’re going to reinvent the matron and give power back to the doctors. We know that isn’t enough; after two or three years in power, you find that isn’t enough. But I just don’t see quite how the political leverage comes to move us to a modern, advanced, delivery system.

The first thing is that there shouldn’t be a minister in charge of it, and it’s no good just setting up a

board, like I tried to do. The first day of mine we had a summit at Chequers or somewhere and Guy's [Hospital] sacked some nurses.

There was uproar and I had to go and be interviewed by the world's press – in our system, if there is a minister accountable, the minister will always be accountable. There's no structure you can put in that really gets you away from that. What the minister should be accountable for – and for nothing else – is broad health policy, for public health, and for ensuring there is universality of provision: making sure that because you're poor, you don't get worse cancer treatment than if you're rich.

Most countries, having come from a different starting point, have ended up with a mix of private and public, with more self-provision. What I do observe is that there is a great, big unspoken area in British political life, which is that nobody is willing to say that we're not now delivering healthcare of the standard a country of this world should be providing. I mean, we are, in bits and pieces, here and there, but not consistently – and some of what we're providing is really very bad now, I think.

I think the current model should change so we have more mixed funding, and so we don't have NICE [National Institute for Health and Clinical

Excellence] saying, “You can't have this latest drug” – you can spend your money on your holiday, but I am not allowed this cancer drug. But I don't see how it changes.

So, the answer to the question “Is it sustainable?” is “Yes”. I think it is sustainable, worst luck, because I really do think that it's not making it possible for healthcare workers to deliver the standards that they could under other systems.

I think Blair did a really good job, and if he hadn't been distracted by wars and things, we might have made real progress – and we did make some progress with foundation trusts and choice and plurality of providers. So I am not saying it is impossible to do. We should go on down that road, but it would have to have some very big further steps, in my view, like no central wage bargaining, and things which sound a long way from healthcare, but are essential – and a braver approach to even more private and charitable provision.

I know one should never go on one's own experiences, but I had a funny little experience the other day, at my local town in Somerset, where I was suddenly potentially quite ill over the weekend. So I tested the GP [general practitioner] service which, I have to say, failed. It just didn't work. Next door to where I was, in a sort of 'third

world' place with people queueing to see a doctor who didn't know where the local hospital was, was a shimmering, new independent treatment centre, which really does work. I thought, well, we can build that and finance that, so why, just across the car park, is the emergency weekend GP coverage such a mess? One saw, for a moment, what the possibilities were. So I'm not saying it's impossible to do.

The alternative of taking the whole thing to pieces and starting again is almost impossible. I don't see how you'd do that in a democracy. It was difficult enough with quite simple things like de-nationalising the telephone system, and this would be a thousand times more difficult.

The problem is that it's a little bit like talking about the navy. I shall get into terrible trouble here, but if you were to say (and I have no knowledge whether this is true or not) that "the navy's not as good as it used to be", there would be bedlam. The admirals would tell you, you were absolutely wrong, and so on, because you have to believe in these things. Therefore there isn't a political groundswell saying, "We want change."

With the provision of nationalised telephones, when people were told that they couldn't have one for two years, they couldn't see why, because somebody could sell them a motorcar the next

week. But you don't see the comparisons here, unless you have happened to live for a prolonged period in another advanced country. So you think, well, maybe this is what health services are like.

I've got a daughter who is just coming up to her last year training as a doctor. She is passionately committed to the health service and extremely proud of it – but what she means by that is that she's passionately committed to fairness; to a fair system, where there are not people who can't get proper healthcare. And so am I. Somehow one has got to separate that commitment from the commitment to this great, huge, sort of grumbling organisational structure.

So, while in an ideal world we would not have started from here – we should not have nationalised all the hospitals and we should pay for it in a way that gives us more control as patients over what happens – I think it is still reformable. But I have an awful feeling it's slipping backwards again now. I don't have much confidence that, if my party is elected, we won't start off in the wrong place again.

Baroness Virginia Bottomley

Virginia Bottomley, Baroness Bottomley of Nettlestone, is a partner of Odgers, Ray and Berndtson Executive Search. She was Secretary of State for Health from 1992–95.

Its fundamental strength has been removing the fear of citizens that they will not be able to fund their own healthcare – that can't be overstated. It has provided an extraordinarily cohesive force within the UK, and for many years it was extraordinarily cost-effective, filtered by GPs [general practitioners] who, overall, prevented over treatment and effectively rationed the system on behalf of the Government in a responsible way.

Its weaknesses have included a lack of consumer choice and courtesy. A tendency to be a 'like it or lump it' service. I can recall, when my children were young, complaining that I'd waited two and a half hours to have them seen in an outpatient department, to which the nurse's response was to take the notes and put them to the back of the pile, because I'd dared to complain.

Is it sustainable? I have reservations. I'm sure the NHS can continue to provide for people's needs, but it can't begin to provide for people's wishes and wants. We are in a consumer society and the generation who were deferential and grateful for the NHS are frequently now demanding, irritated, unappreciative, and they expect a quality of care and courtesy that is almost impossible to deliver.

That is extremely hard for NHS staff, and probably unrealistic. In today's generation, people spend a fortune on gyms, personal coaches, cosmetic products, homeopathic remedies, and expect a huge amount from the NHS.

Then with the advances of science there will be ever-greater challenges, and I think the pressure is going to be on the GP because, traditionally, the GP has been the trusted interpreter of the NHS, the individual who managed your health and care, who could be implicitly trusted. In the past, on the whole, the GP did not inform patients of treatments which were available but unfunded by the NHS. But increasingly there will be all sorts of treatments and interventions which could be beneficial, but are financially likely to be beyond the reach of a taxpayer-funded system, and I think this will put them in a great difficulty, if they're to retain the trust of patients.

So, if we're to continue providing a comprehensive service which meets need, as opposed to wishes and wants, we've certainly got to make difficult decisions and be prepared to do so.

One of the most telling experiences I had was the *Child B* case.¹ I suppose many politicians would find that a difficult choice, but having established that the clinicians at Addenbrooke's and at the Marsden (which were the two hospitals involved) were of high quality, it seemed evident that to

1. The case of a girl with leukaemia, known as Child B, which attracted considerable press attention in 1995 when her father took Cambridge and Huntingdon Health Authority to court for refusing to fund

chemotherapy and a bone transplant in the private sector. *R v Cambridge Health Authority ex parte B* [1995] 1 WLR 898.

overturn their decision that this child should not be offered further treatment would make comparable decisions impossible for anyone else in the health service. It must be cost-effective care, and that is what we must strive for. I think some politicians find that quite difficult to endorse.

It's a huge challenge to provide a national health service and it can only be done if leaders are prepared to make brave but principled decisions which do not fall over in the light of a publicity campaign. There would have been a dilemma, had my advice been that the hospitals involved were of less medical authority. I would have found that more difficult.

In terms of how else the NHS should change, I've long strongly been in favour of greater independence for the NHS, with a board and an independent chairman, and a constitution. So I'm delighted that that's what the Tory front bench is promoting. The comparison, I suppose, would be the Bank of England. The governor of the Bank of England is a person above politics. I think the NHS needs a chairman of authority and weight, who has the ability to tell ministers to back off, because the recent years have been a textbook example of order, counter-order, disorder, reform fatigue, endless targets, imposed often in the most deplorable political style, by press notice and top-down. Anyone from the commercial world would

recognise the value of targets, but they need to be owned by the organisation, built bottom-up, limited in number and consistent.

It is impossible for the chief executive of the health service. They're too closely enmeshed in the party political process and constantly responding to political imperatives, rather than delivering the service and leading their troops. A board would provide some insulation from that.

I'm sure the chairman of the NHS would be an individual who had the political confidence of the party in power, rather in the same way as when Alan Leighton was appointed to the Royal Mail, or David Varney was appointed to HM Revenue and Customs. So when the unpalatable truths needed to be articulated on behalf of the NHS, it would be easier for that individual. The long and the short of it is, if you want to have 24-hour A&E cover, comprehensive coverage, that cannot be done unless it's basically focused on the essentials.

Throughout NHS history there's been a kind of centripetal force that keeps dragging power back into the Centre, sometimes even when politicians desperately don't want it.

Kenneth Clarke was instinctively right in his vision that the NHS should move its headquarters to Leeds, so it would have more of a separate

identity. It was in fact impractical, and the effect was to wear Alan Langlands² out because he spent his entire time on a train with a suitcase. But the idea is the right one.

Another weakness of the NHS has been the failure properly to get doctors into management. If you did a personality assessment as to the people who are going to become managers and the people who are going to become clinicians, you're looking for different skills and qualities. But it is interesting that in universities, vice-chancellors are academics. That is a fascinating contrast.

I do think clinicians brought much of this on themselves. They were insulting to managers – they used to talk about them as administrators. Then doctors were allowed to become managers, but they were rarely allowed to become leaders. If you look at a company like ICI or GlaxoSmithKline, they've got brilliant scientists, but the skills and qualities of the chief executive of those enterprises is recognised – and maybe traditionally it remains that very bright people become clinicians; whether our best managers are yet going into the NHS is, well, open to consideration.

So I very much hope that we will see greater progress in clinicians becoming managers. I'm just slightly surprised that in the 10 years that I've been out of that world, it remains such a relatively rare career path. That may be about prestige. I

think health managers feel fairly beleaguered. There are lessons from the commercial world. If you've been at a retail bank or Tesco and your job has been to shut down a branch, a difficult job, you're likely to be rewarded for the difficult job and then given an easier job next time round. In the NHS, the managers charged with handling many of the closure programmes often become the scapegoat themselves – and they feel pretty unsupported by the process. They rarely feel that they've then been rewarded for their pains by a job which is easier next time round.

I was lucky as Health Secretary because I followed Ken Clarke. He had made a big noise and introduced the dramatic changes, and I'm second to none in my admiration for him. I think he saved the NHS in many ways.

The disappointment I suppose is that Labour – with that welcome boost of resource for which they need recognition – basically squandered five years. They did two things in that. They failed to use the extra resource to incentivise the necessary changes, and they sapped managerial confidence and authority by making so many changes [in terms of reorganising the health authority/primary care structure of the NHS].

Twenty years on from Ken Clarke, it does feel as though it is almost back on track. There have been some very interesting developments. If you're

2. Chief Executive of the NHS Executive 1994–2000.

going to have more of a market model – more choice, greater range of providers – what the consumer, the patient, needs is confidence in the quality of the choices. So having an inspection regime which covers both the independent sector and the state-funded sector must be the way forward. I hope the Care Quality Commission is able to deliver that. It seems it's a necessary prerequisite for more flexibility in the market.

But if only we'd gone the way we were, to where we are now. On the funding side, there are all the pressures we talked about earlier. Already we know on care of the elderly, social care, there is a somewhat arbitrary form of co-payment, and there is in dental services, possibly excessive co-payment. It is interesting that in Sweden, co-payment has long been the norm, and in many other countries round the world. There are very few countries in the world who even attempt to suggest that everyone should have everything forever for free.

I'm sure there will be a growth of self-pay. I think that much of it will be employer-led. But funding is all a no-go area currently. I'm interested that Labour hasn't moved more on it; I thought there were moments when they might have done. The iniquity of the prescription system is extraordinary. Fewer and fewer people pay more and more – but you can be a wealthy pensioner and still have free prescriptions. It's not rational. So I think there will

be some gradual erosion or movement on the payment front, and there will be more employer activity before the matter is reviewed again.

All that said, I think it will remain the NHS. It is such a highly-valued universal provider. People really do want to feel it is there for everybody, and when they fall sick it remains for most people the provider of choice.

I think it will get to 70 years. But what happens after 70 years... well, maybe some of these underlying principles will be reconsidered.

Rt Hon. Stephen Dorrell

The Rt Hon. Stephen Dorrell is Conservative Member of Parliament for Charnwood. He was Secretary of State for Health from 1995–97.

The NHS has plenty of problems, but one of the things we got right in post-war Britain was the basic insistence that you get access to healthcare on the basis of need, not ability to pay. I think that is as strong now as it has ever been, and it's the right approach to dealing with health.

Achieving that principle is the objective of public policy. It is an aspiration that will always fall short of the ideal, because you cannot provide everything for everybody all of the time. There will always be difficulty achieving it, because the challenge for managing the service is achieving the balance between universal access and cost-control, value for money, efficiency and so forth. But it is the right ideal.

More generally there is also a balance to be achieved with clinicians who want to feel their judgement is respected. They want the freedom to do what they see as being in the best interests of their patients – and that is right and proper and good, but has to be balanced against value for money and efficiency and the other factors.

One of the problems of the NHS, I guess, is still its responsiveness in comparison with what else

we are used to in other walks of life, where parts of the private sector will bend over backwards to look after their customers. There are plenty of clinicians who do that too. But the NHS at its worst still has a tendency to say, 'You are just not entitled to that... go away.' At its worst it comes close to still having a sense that it is state charity for which you should be grateful.

That still lingers in the culture of the service. It is more deeply entrenched in the NHS than in many other parts of public life, because of the culture from which it was born.

Is the NHS sustainable? I think the core idea is sustainable. Offer me an alternative aspiration for health policy which will ever get the level of support either from patients or from taxpayers or from professional staff. The aspiration of what the NHS stands for is deeply entrenched. But if you ask, 'Has the model been got right?', I don't think it has yet.

There are undoubtedly continuing pressures for change in the way the service is run and those won't go away, but plenty of people have toyed with different ways of funding it and they are all ultimately unconvincing. The great majority of the money will always come from general taxation. That is true in every western country, and even in the USA the taxpayer funds a large and growing part of healthcare costs. The US system has

relatively few lessons for us, it seems to me, and tax will be the core of health funding for the rest of my life and well beyond it.

What role is there for private funding? Well, it is a relatively small proportion of total health expenditure. There is clearly a role for individuals to choose to self-fund. It would be inconceivable not to allow people to do that – and there is some role for co-funding in maintaining a healthcare system that is fundamentally tax-funded. We have always had some – prescription charges, charges for eyes and teeth – increasingly we should recognise the extent we have it for care of the elderly, and we need to recognise that care of the elderly is fundamentally the same sort of service.

Should we extend that into other clinical services? I don't think we should say that is inconceivable, ever. But we should not delude ourselves into thinking that to extend co-funding a little will significantly change the map away from tax funding.

Clearly there are pressures on the health service from ageing, from technology and from rising expectations. But those pressures were first identified by the Guillebaud report in 1956¹ and it is absolutely untrue to say, as people tend to do, that they are new. They have been there throughout the history of the NHS and, for all the frustrations associated with it, I would argue that

the NHS has been one of the better mechanisms for reconciling these pressures that exist in all western health systems. But might not those pressures now be qualitatively, or quantitatively, stronger than they were? I don't think so. What has changed is the balance between the collective and the individual within wider society, and that – the demand for a more individual service – is a challenge for the health service. To recognise that is not to walk away from its collective aspiration, which I think is overwhelmingly right. The challenge is to establish some mechanisms to deliver a more individualised service to the best of our ability in a political and social culture that is different to post-war Britain.

But it will still be a National Health Service, for a number of quite important reasons. First, and most importantly, there have to be variations around the service for all sorts of reasons. But among clinicians and patients and taxpayers there is very little tolerance for the argument that services can be radically different in Bournemouth to Bridlington. We can accept that for Scotland and Wales, but there is much less tolerance for county by county or postcode by postcode differences.

There will always be some role for co-funding, or charging, and insurance to support that. But I emphasise it will always be a marginal element of policy.

1. HM Government. *Report of the Committee of Enquiry into the Cost of the National Health Service in England and Wales*. London: HMSO, 1956.

Where the private sector can play a role is on the delivery side of the NHS; and one of the biggest changes has been that there is now a total acceptance – well, not quite total – of that across the political parties.

Fundamentally of course, there has always been a private-sector role, in that general practitioners are independent contractors. But there is now an acceptance that there is nothing wrong with the public sector purchasing services from the private sector, provided they deliver quality, safety and value for money, and we should be continually exploring that. We [the Conservatives] sort of started that in the 1990 reforms and it has taken 18 years to become a broad consensus, but I am delighted by that. The big disappointment is how long it has taken to get there.

One thing we have never got right, however, is the balance between lay and professional management, and the clinical professions – I am talking about day-to-day management responsibility now. Professional independence and accountability was, to some extent, a casualty of the management reforms of the 1980s and the internal market of the 1990s. That changed the terms within which professionals operated. And when Labour, in a large measure, reversed that in its earlier years, it replaced the pressures that the market reforms had brought with the imposition

of even stricter management control through central targets. So professional independence suffered throughout the 1990s and then suffered further from the introduction of targetry.

The way back, it seems to me, is to build the professional angle into the commissioning process, so that commissioning should involve the professions rather than be done to the professions – not least because it is probably the only way to achieve effective commissioning.

Does the NHS need a board or a constitution? Political involvement is inevitable because it is tax-funded. It is the ‘*Today* programme test’. If something goes wrong – as inevitably does in a service that treats a million people a day – the *Today* programme rings the Department of Health. What does the Secretary of State do? He or she says, “Nothing to do with me guv’, ring the manager in York or wherever.” But if people have lost confidence, it is not the manager in York who has to answer. The people held responsible by the voters are the politicians, and they want to know what the Government is going to do about it.

Now any intelligent Secretary of State tries to make the point that they cannot make every decision. They are responsible for the results but not for every decision, and the only way to optimise the results is, as far as possible, to make

people responsible for deciding things at a local level – but that only gets you so far if something goes fundamentally wrong.

So I am not against the idea of a separate board to run the NHS, so long as no one believes that if something does go fundamentally wrong, it will get the politicians off the hook. It is a perfectly sensible proposal to try to push decision-making further down the line, but it won't fundamentally change the political nature of the service.

If I have a sense of frustration, it is that it has taken so long to get past some of the political arguments around the NHS reforms. When we launched them in 1990, all the rhetoric was that this was the end of civilisation as we know it, that we were aiming to privatise the health service. Arguments were put up against what we were doing that were verging on the dishonest. Now almost all of that political argument has gone, but we are still talking about some of the same things we were talking about in 1990s: that commissioning is weak, that it needs strengthening and that it is the absolute key to success. I heard Paul Corrigan give a speech to that effect in 2006 and [Tony] Blair make a similar one just before he went. They were both good speeches; I agreed with almost every word of them. But then I had heard Sir Donald Acheson, the chief medical officer, saying exactly the same thing in Ken Clarke's office in 1990 when he

was Secretary of State and I was a junior health minister. It has taken 18 years – a long time, too long a time.

Were there mistakes I made, things I would have done differently? On that one I'm with Michael Heseltine who, when asked on a public platform if he had made mistakes, said that he was "humble enough to admit that he had made mistakes but shrewd enough to have forgotten what they were".

I did not get a lot of money out of the Treasury, that is true. We had had huge increases in the early 1990s and that wasn't able to continue. Spending was tighter anyway across the board, and the Treasury did want to insist on some efficiencies coming out of the reforms.

Expectations are a problem, and particularly the way Labour has raised them. It is better to downplay expectations. Every year the NHS has done slightly more than in the previous year, and if you do slightly better than you expected, people feel good about it. I am not against the service having ambitions – my White Paper was called *A Service with Ambitions*.² But when you have had this monumental increase in money, and all the talk about a world-class service, without any very clear objectives about what you want to spend it on, the result is likely to be disappointment.

2. Department of Health. *The National Health Service: A Service with Ambitions*. London: HMSO, 1996.

It is not that the NHS has not got better under Labour. Of course there have been improvements, but the improvements have been disappointing in the context of the scale of what has been committed. Labour has not helped itself by all this talk of a world-class service. If you set an absolute target like that you are always going to fall short, because however much healthcare you deliver, there will always be someone at the margins whose needs have not been met or who has been disappointed. In most walks of life, if we have more this year than we had last year – as has been the case with the NHS in almost every year since 1948 – we count that as progress. But if you set an absolute objective you will fall short, and that raises awkward questions about the gap between the aspiration and the reality.

On localism, the problem is that we tend to be pretty intolerant of local differentiation and we say we must have a national blueprint that is rolled out everywhere. But the fact is that there are differences locally, local structures differ, local populations differ, patients differ, every locality differs – and you need local variation if there is to be progress on anything. If everything is uniform, there is no learning going on. We need to recognise more that there will be variation, and that that is a good thing. We need to have a system that acknowledges that, but is transparent, so that we can see what the differences are and

learn from them. You cannot get progress from uniformity.

An important and emerging theme is the importance of outcomes, and how we build that into the commissioning process. It is depressing that the health debate is so often about the location of maternity units or Accident & Emergency departments, and so rarely around the differences of outcome that different arrangements can bring. We need a much greater focus on outcomes and the variations in those around the country, because they are much greater than they ought to be.

We [the politicians] will have to win the argument about that, rather than have arguments about buildings, and structures and so forth. We have not been good at challenging poor clinical outcomes.



Baroness Julia Cumberlege

Baroness Julia Cumberlege, CBE, is Vice-President of the Royal College of Nursing and the Royal College of Midwives, and founder and Director of Cumberlege Connections Ltd. She was Parliamentary Under-Secretary of State for Health from 1992–97.

In my view, the greatest strength of the NHS has been that it has provided healthcare, largely free, to anybody who needs it – whether they're black, white, young, old, rich, poor – *in extremis*, they get healthcare. The great success has been maintaining that ethic, which is very difficult when all the other organisations that were a government monopoly have been privatised.

It has survived because it's a socialist Christian, perhaps Judeo-Christian, ethic. In the United States and perhaps some other countries, there is a great fear that if you are poor, old and sick, your insurance will run out (if you have it), or you get a very, very poor service. Any government who did away with the ethic would not get re-elected: it is very popular with, and very deeply rooted in, the British people.

The greatest weakness has been the failure of the NHS always to put the patient at the heart of the service. So often, it's run for the people who work in the service, for their convenience, rather than for the patients. For example, if one considers the

gowns that patients have to wear, they're split up the back. Who would go and buy something like that in a shop? That is degrading, and the gown is used because it's convenient for staff, but it does nothing for people's self-esteem when they're at their most vulnerable.

The NHS has got marginally worse, partly because of the pressure of throughput. It is difficult, especially in acute services, to build a relationship of respect with the patient. I don't believe the NHS is the envy of the world. It used to be extremely cheap, but is much less so now. People are still intrigued as to how we've managed to keep this ethic alive. The service is not as good as in France and Germany, and possibly Canada.

Why? The NHS is a near-monopoly, so you have to introduce all sorts of other methods of trying to raise efficiency and quality. Another monopoly I've been involved in is the water industry. Here you don't get any choice, and to get the water to flow to every house is a mechanical, technical problem. You don't need to work up that very difficult relationship which you need to do when people are at their most raw and most vulnerable, their most sensitive, as you have to in the health service.

There will always be a basic service that is tax-funded. If one was to abandon the NHS, you would go to a totally different system which

would be an insurance system, or something similar, for example, as in France and Germany – and I don't think the country is ready to 'wear' that, not yet. It's very expensive and the employer has to pay a large percentage of the cost for their workforce in terms of healthcare.

Although I feel passionate about retaining the ethic as far as possible, it will get eroded. I don't think any government is brave enough, or foolish enough, to abandon it, but what we will see is the introduction of top-up fees. If you look at dentistry, it's virtually gone from the NHS, and even in the NHS it's very expensive to go and have treatment now. I don't think we can have everything free at the point of use.

We're already having people who are saying: I'm prepared to pay the extra for this drug that is going to extend my life by a matter of months perhaps, or at best one or two years. The government doesn't dictate what food I eat, it doesn't clothe me and yet, something that is so precious – which is the length of my life – I'm not allowed to invest in unless I go 100 per cent private, which is very, very expensive. Technology and science enable us to do so many things today, and that's going to increase. So, the pressures are going to mount, and I think that will rock the NHS.

I just don't think it's sustainable with demography, new technologies and people's expectations.

Elderly people today are still grateful for what they receive; my generation is not. We expect more, a service that is in line with the rest of our lives: open access, 24/7, as one gets in the supermarket. You don't get that from your GP. We expect very good environments in terms of the buildings and what's in them. We expect really good service, and if we don't like it we go elsewhere – and for many people that isn't a choice in the NHS. It is very interesting if you look at maternity services. The average age for a mother having her first child is 29. Now, many are women in mid-career and some are managers – they know what good service is, what good management is. And when they go and have their baby, some of them are appalled by the service they get. It is possible for a public service to become sufficiently responsive, but it takes a lot of training, effort and recruitment of the right people for the right posts.

One of the other failures in the NHS has been the inability of any government really to get the medical profession into leadership positions within hospitals, within services, and to make GPs a real part of the NHS 'family'. I think this is the last chance for doctors, I really think this is their last chance. In the past they tried to get doctors much more closely involved in trusts that were set up by Ken Clarke, and some became medical directors. The vindictiveness towards some of them because they were trying to bring some of their colleagues to account! They did not want to be associated

at all with management. And yet we know that doctors are some of the brightest people in the land, and can be very politically astute if they have a chance to be educated in the politics of the country (or the ‘black arts’, or whatever one wants to call it). Yet they’ve chosen to walk away from what could be very rewarding and interesting jobs.

They don’t understand half the challenge of the difficulties that managers face. But where you get a really good relationship with the chief executive and his medical colleagues, wonderful things happen. I think a really good example is Dr Jonathan Michael at St Thomas’s [Hospital]. In America you never have a hospital that isn’t run by the medics.

At the moment I’m trying to teach specialist registrars about management and politics (with a small ‘p’). The anger among some of them! They realise that they’ve been working in the health service for six years and they’ve never met the chief executive, they don’t know how the system works, and they don’t understand the politics. It is the politics – internal to the management of the hospital and national politics as well – that comes and hits them when they least expect it. I think it was Nelson Mandela who said that if you tell people, they’ll forget; if you show people, they won’t remember; if you involve people, they’ll understand. There isn’t nearly enough effort

to involve junior doctors so that they can really understand the business in which they’re going to spend their lives.

Clinicians are wary of politics and politicians, and it’s very strange for an organisation to have its top board composed of politicians. There is a role for government, particularly in resource allocation and in public health. But I have long fought to try and get the running of the health service independent of politicians, because they do it so badly. In fact, I’ve put down six amendments to two major health Bills to try and get that to happen. I had enormous support from the cross-benchers, a little from my benches and none from the Government, because there is much less for politicians to do today, with Europe taking some of the authority and government. Devolution has meant that English politicians have lost quite a bit to Scotland and less to Wales. The one area which affects a lot of people’s lives is the National Health Service, so it’s very hard to wrench it away from the political process. More and more politicians don’t have any other outside interests. They’ve given up the day job to be full-time politicians, and that’s very unhealthy. And that’s where we score in the House of Lords.

The other thing is about democracy within the health service. Where you have a monopoly, it’s essential to have influence by the people who

live in the local area, who know it well, and who should have some say in the shape of the services around them. I do think there's a very strong role for local patient public groups, especially at the commissioning level. I have been really disappointed by the demise of CHCs [community health councils], the introduction of patient forums, which were even less powerful, and now we have LINKs [Local Involvement Networks], which seem to me to be totally powerless.

The Government does get very fed up with the inefficiencies in the NHS. I do believe that there is rigour in the private sector that could really have a beneficial influence on the NHS. I have been impressed by Monitor – within foundation trusts they have actually introduced a discipline in financial and efficiency terms that was lacking before. Also, the Healthcare Commission has had a favourable impact, and so have organisations such as Dr Foster, where they are very keen on benchmarking so that people can make realistic choices. There is a belief in government that if you enshrine something in legislation or even in guidance, it's going to happen – and it doesn't. We have a policy on everything. We don't need more policy – we need better implementation.

Rt Hon. Frank Dobson

The Rt Hon. Frank Dobson is Labour Member of Parliament for Holborn and St Pancras. He was Secretary of State for Health from 1997–99.

The service’s greatest strength is that it’s the most popular institution in the country for two reasons. For most people, most of the time, in most places, it does a very good job. But I also think people like the idea that it’s doing things for everybody. So my emotional way of describing it is that besides binding the nation’s wounds, it actually helps bind the nation together, at a time when most of the forces in working society are fragmentary. It’s a binding force. So in some ways I think that is its greatest characteristic.

Its weakness has been the vulnerability to the problem of political timescales being infinitely shorter than healthcare timescales. Its vulnerability has been to successive governments introducing changes, and then just wanting instant gratification for their changes – and when it doesn’t happen, they then make some more changes.

It has some of the characteristics of a supertanker, but it’s actually more like a convoy in that some of the ships can turn round a lot quicker than others, and in some specialities you can turn things round and improve them quicker than others. One of the criticisms often made is that it is a monolithic

organisation – that’s the last thing it is. If it was a monolith of all the best things, even the management consultants would say you should leave it alone.

If you ask me whether it is sustainable, well, it may not last, but that won’t be because there’s any evidence that it can’t last. All the evidence says that it does work, it could work better, and it’s capable of improving itself. People asserting that it can’t do things and that competition will improve it – that’s all faith healing.

There wasn’t a jot of evidence when various think tanks and other vested interests started advocating competition, and all the evidence that has accrued since is to the contrary. If we’re talking competition, you’ve got the competitive system of all competitive systems in the USA, which is now in such a terrible state that all the candidates for president are proposing radical change and [Arnold] Schwarzenegger, the Republican Governor of California, is actually proposing a California-wide compulsory healthcare system.

People who say that the combination of demography and technological advance will break the model – they just assert that. There is no evidence of this at all. Where is the money to come from if it doesn’t come through the present system? Somebody’s got to pay for it, and it is undoubtedly the cheapest way of doing it. Even

the right-wing nutters don't assert that private insurance would be a cheaper and more cost-effective way of doing things. So that's the income side. As far as the technology side is concerned, you could extend NICE [National Institute for Health and Clinical Excellence] to a further sphere of technological change.

NICE has been very successful. It does appear to be the envy of most countries, and that envy manifests itself by them using it and following its recommendations. Last year they had 72 million hits on the website, 36 million of which were from the United States. Looking at its example, Congress recently voted to set up an American NICE – needless to say, costing about 10 times as much. Again, look at America. The American system, it's the most unfair in the developed world: it is almost twice as expensive per head as any system in the developed world, and its costs are rising faster than any system in the developed world, which somehow suggests to me that this not being able to cope is more likely to be a characteristic of competition than cooperation.

The NHS is among the most cost-effective in the world in terms of money versus performance. So why should it cease to be cost-effective if costs rise? It's like saying, 'Oh, there is a cloud on the horizon. Let's take down the marquee and sell everyone an umbrella.'

There is, at the heart of any system, a potentially abrasive connection between professional discretion and trying to manage to get the best value out of a system. I think that applies to any system, and it will always pose difficulties. It is very difficult to override clinical judgement in order to get best value. I don't think there should ever be any management interference with that judgement, otherwise there's no point in having the judgement of the skilled practitioner – but you can have a body like NICE, where the collective judgement of doctors and others overrides the view of individual doctors.

There is a problem with a tendency for ministers to get too involved in the day-to-day running of the service. The fact is that if something goes wrong, the public and news media will say, 'They must do something.' The 'they' that they are talking about is the Government, so there is a bit of difficulty there. I did do my level best not to get involved in the day-to-day failings, or otherwise, of individual hospitals. I remember there was a real sharp intake of breath when somebody asked me in the Commons what I was going to do about some hospital in south London. I said it was nothing to do with me, it was up to the management and the doctors to sort it out. I'm told it totally put the wind up the management at that hospital; more so than if I'd said I'd come down on them like a ton of bricks, because they have all faced tons of

bricks before – which either were never delivered, or missed.

I do think it is right and proper that from the centre there should be some forms of measurement introduced and insisted upon. They shouldn't necessarily be targets, but there have to be some measurements.

I don't think you can justify on the basis of local decision-making, local managers saying, 'We decided to be slovenly in our screening programme so some people will die of cervical cancer.' There have to be certain things that are laid down. The problem comes when politicians say not just 'this is what we want done' (that's legitimate), but then say 'and this is the way you will do it'. I don't think I did that, but my successors certainly did.

That leaves no discretion to management. No room for initiative, no room for new ways of looking at things, no way for reflecting the particular needs or opportunities of the area. For instance, I'm sure there are quite a few places where polyclinics would provide a better overall service to the local people. On the other hand, there are plenty of places where a polyclinic would be wholly inappropriate, and a variation and updating of the present arrangement would be better. So it's saying, 'These are the qualities of

care and treatment that you should be providing. But it's up to you to decide how best to provide it.'

Oddly enough, looking back, we were actually criticised for not having enough targets initially. It was suggested we should continue the Tory ones. I think the Tories had an overall target for teenage pregnancies and, as I pointed out, there are some parts of the country which would have had to get to work to *raise* their level of teenage pregnancies up to this national standard, which I don't think was the idea!

I don't support the idea of an arm's-length board. Some people would say that it means that ministers would be no longer be held responsible, and that would be a good thing. All I can say is that we have a privatised railway, and when there's a rail crash it isn't the boss of Railtrack who appears at the Despatch Box in the House of Commons and gets slaughtered by people from all sides – it's a minister. They're never going to be able to get away from having the responsibility. Indeed, they could end up in the ludicrous situation of having responsibility without power, which is as bad a combination as power without responsibility. I think there might be a better way around that, which is to have an advisory board representing the professionals and patients and so on; and that no significant policy changes should be introduced without it at least being subjected

to detailed, careful and lengthy scrutiny by the aforesaid policy board.

As far as local authorities are concerned, I have never been in favour of structural change in the NHS very much. It is very doubtful whether any of the reorganisations have had any benefits of any consequence at all, really. All change consumes resources in terms of money, time and distraction. It needs to be absolutely guaranteed that what you are changing to is a lot better, just to compensate for the downside of the period of change.

However, I have always believed that one of the worst aspects of the Keith Joseph reforms in 1974 was taking the Medical Officer of Health function away from local authorities. They were high-status persons in the local authority. They couldn't be dismissed without the consent of the Privy Council, so they were protected from malignant local interests getting elected on to the council. Whereas now the function that was previously carried out by the Medical Officer of Health is probably part of the job of somebody on the second or third tier of the primary care trust [PCT]. I don't think that taking this function away and giving it to local authorities to strengthen public health would be much of a structural change. Whether they should then have the commissioning function – and in effect you have a

PCT which is the local authority or a group of local authorities – that would certainly be a possibility. Put it this way: if you are going to have a change like that, it would be a lot better than having an elected PCT. I would be firmly against separate elections for them.

Rt Hon. Alan Milburn

The Rt Hon. Alan Milburn is Labour Member of Parliament for Darlington. He was Secretary of State for Health from 1999–2003.

Its greatest strength has been its cultural expression of a set of values that people in Britain are particularly attached to – for good reason. We all pay in according to our means and we take out according to our needs. In a world which is becoming increasingly atomised, it is part of the social glue that binds Britain together. In some areas, for all its problems, it has probably led the world – in primary care for example, while in terms of its public health its vaccination programmes have again set the pace. Most important of all, it has just become an enduring expression of the pride that the people in this country take towards a very particular, peculiar almost, system of healthcare. And its values are in some ways even more relevant now, given what we are likely to see in the first really big breakthroughs arising from the genetics revolution. The advent of these more individually sensitized systems of assessing health risk, if anything, strengthen the case for a collectivist system of healthcare.

Its greatest weakness has been that it failed to keep pace with the times. When we got in, in 1997, there was a very strong sense that its principles might be right but its practices had become outdated. That it was too inward-facing. It was too concerned with the interests of those

providing the service, and too little concerned about those who were using the service. And for all the talk that uniformity of provision would deliver uniformity of outcome, actually over the course of 50, 60 years, inequalities between rich and poor in health terms have got wider, not narrower. There are certain things that only your best friend can tell you. And the National Health Service has got some profound weaknesses, which I think are being addressed, but which have got to be – the journey’s got to be finished. What we are seeing is a transition between one system, which is a mid-20th century way of organising care that is top-down, monopoly-provided and driven, frankly, more by the interests of producers than consumers, towards a system which is more bottom-up, is more diversified in terms of its provider base, and which is ruled by the interests of patients. The destination of travel is clear.

I suppose the issue now is whether the journey is completed or truncated. Having started down this path of quite fundamental change, the only way to complete it is to move forward, not back – and to finish it. I think that’s where some of the interest in the 60th anniversary lies. People still want to complete the journey, but they’re uncertain whether that is still the direction of travel. One of the jobs that you have to do, if you’re in charge of the system, is to be absolutely crystal clear about where you want to get to. And the biggest thing that is now needed is just to

hold on to the clarity about finishing this journey. I think there are several aspects to that.

One is that you've got to complete the journey from national to local. So, of course, there should be a limited set of national standards, and of course there should be open systems of accreditation, inspection and regulation. But essentially the move should be towards more bottom-up than top-down accountability. To achieve that, foundation trusts should become universal, and the drive for that should be absolutely with the foot on the accelerator, not the brake. As far as commissioning is concerned, in order to get accountability in the local community, rather than in Whitehall, primary care trusts' [PCTs] functions should move to those local authorities who are capable of demonstrating that they have the ability to run commissioning for health as well as social care.

Journey two is to a system where it is run less by standards and targets and more by incentives and the views of users. A partial democratisation of PCT commissioning would help do that. And we've got to move increasingly towards outcome measures, and an assessment of the views of users – so that the user view begins to have a sharper effect on the accreditation that the individual organisation gets.

Third, we have to complete the journey from public sector to public service – by which I mean that the introduction of competition won't work in every aspect of service, in A&E care, for example. But there are still whole swathes of the NHS and social care system which are deeply monopolised, and which have got to be subject to a level playing field where the public, private and voluntary sectors are able to compete on equal terms to provide the service according to the quality of care they provide, and the value for money that they can extract.

Then the final journey, which is the most fundamental, is where we move from giving patients some element of choice, to giving them real control through individual budgets. We've got to make the leap, particularly for those with a chronic and debilitating ongoing disease where a lot of the costs are entirely predictable. We also know that patients are far more inclined to make conservative decisions than clinicians. So why not give them the budget and let them shape, or help shape, their own healthcare?

If you did those four things – all journeys which are begun, not yet finished – they would take you to a service that was entirely recognisable by Nye Bevan: free at the point of use, driven by need not ability to pay, collectively provided out of general



taxation, but one which was a 21st-century model and not a mid-20th-century one. And I think that the forces that are changing healthcare, not just in this country, but worldwide, make it inevitable, at some point, in some form, that that sort of model will happen. You can't put the genie back in the bottle. I don't know of any precedent in history where you give people more freedoms and more choices and suddenly people want less.

They want more. I think the trick for parties of the Centre-Left, particularly the Labour Party that has such a close affinity with the National Health Service, is to prove that this sort of collectivist model can work in a way that preserves its values and integrity, but which is attuned to a more individualised world.

Devolving power locally

The argument for local authority commissioning – where a local authority passes a performance hurdle – is that for the first time, notwithstanding all the legal and financial problems, you'd have one organisation in charge of the whole spectrum of care, ranging from housing, social, leisure through health. Second, you'd get a proper separation of providing and commissioning in community and primary care-based services – and that needs to be sorted. Third, you would help

solve the democratic deficit that still lies at the heart of the way the NHS operates.

Finally for me – the thing that I learnt – was that you cannot rely upon ministerial good intent to devolve power. The temptation as the health minister is always to nationalise responsibility rather than to devolve it, even though you know that you shouldn't. Because the pressure – media, public, patient, professional – is to get something done: 'Go and sort it out.' And the consequence is that you have an accretion of power to the Centre. The only way to deal with that is to cut the ties that bind, which was really part of the thinking behind the NHS foundation trust hospital model as well. When you just say: 'Right, I've now got no remit on this page – it's over to you guys. But you will be held to account.'

Whenever I speak to an audience abroad about the NHS having 1.4 million employees and growing – people laugh. Of course they do. Because it's perfectly obvious that it's ungovernable. So what you've got to do is get a proper separation of responsibilities and power within the system, so that the Secretary of State and the Department do what they need to, in terms of setting some minimum standards and providing the resources on a fair and open basis. They need to be able to hold the overall system to account. But the authority to make things

happen has to be devolved to where the action is. Healthcare isn't delivered in Whitehall, but it is delivered in Darlington.

I don't buy the argument that technology and demography will break the bank. In each successive decade you've had the advent of a new technology of treatment that was going to break the bank. And when I look at the growth in the numbers of elderly, the growth, of course, is steep, but probably less steep in terms of absolute numbers than the previous 20 to 30 years – and certainly far less steep than some of the comparable nations. Furthermore, technology is a double-edged sword. Forty years ago, if you and I had had an ulcer, we would have ended up in hospital. We would have ended up with a deeply invasive operation, which was probably pretty dangerous and it would have cost a lot. Nowadays you pop a pill. You can see the possibilities of new technologies, whether pharmacogenetics, or tele-medicine or the interesting developments taking place in robotics and surgery. But in cost terms, all these things are, I think, genuinely double-edged.

I don't quite know what people are saying when they say 'it is unsustainable', because when it comes to healthcare, there's no such thing as a free lunch. One way or another, you've got to pay for it. Are people saying it's got to be some form of health insurance? Well, okay, but there's a

group risk problem: the most important of which is that the people who need healthcare the most and use it the most, the very young and the very old, are those who are least able to afford to insure for their health needs. Is it that somehow, we're going to lop some treatments off – in which case, which and how? What are we going to do, have a popular vote on it, à la Oregon? What's it going to be? I don't quite know what it is that people mean by some of this, to be honest.

I think where it gets tough for the NHS is that NICE [National Institute for Health and Clinical Excellence] has been pretty good at shifting cost into the system. The issue for the next phase is, as it shifts costs in, is it capable of taking costs out? In other words, can it identify existing treatments and technologies that don't pass the effectiveness hurdle, and take them out? That is really tough, but if you're in any other walk of life, that's what you do. You don't heap the new on top of the old. You replace the old with the new.

There is also a real pressure from the infrastructure we have created with NICE, where there are some things like some of the newer cancer drugs that may be effective at the margins, but NICE does not judge them to be cost-effective. That does lead to calls for people to be able to top up within the NHS. If that's what people are arguing about, well, let's have that debate and argument. It may

will be that there is a case for flexibility there. But it doesn't alter the central case. The central case is that for the vast majority of patients, the vast majority of the time, for the vast majority of treatments, people get their care on the NHS. That is what happens. In a minority of cases, of which NHS dentistry is probably the best example, there is some element of top-up.

In my model, if you move to a single commissioner of social and healthcare services, you'd have to accept that there would be a capability of moving between health and social care budgets and vice versa. I understand that. Nonetheless, I don't think anybody is proposing that the health services adopt wholesale the means-testing system that is absolutely integral to the delivery of social care. One of the other issues with my model of a democratically-elected local authority in charge of commissioning is that I see no reason why it shouldn't be given powers to raise additional resources locally – subject to popular referendum.

So if the local authority makes a case and says:

Actually, folks we've got a more elderly demographic profile than the national average, and that is incurring more cost both for the health and social care system, so we need to put the council tax up – whatever the system is

– and would like to be able to make the rise this year 6% rather than 3%...

In my view it should have the power to ask and the public should have the right to vote on that on the same day that they vote in the local election.

That is very different to all this talk of having a national board to take politics out of the NHS. I really feel strongly about that. It takes us in completely the wrong direction. First, it takes us towards a policy of nationalisation, not devolution. If you want to have a National Coal Board, then the right time for that was 1948, not 2008. And my second argument, that I know from my own experience – notwithstanding many of the very good people I've worked with in the Department of Health – is that all of the big reforms were led politically and not administratively. So if you want to have the great and the good back in charge, then fine. But I accept that the great and the good, being in charge of the NHS for 50 years, got it to where it was, which is highly efficient but non-responsive. Good on fairness, hopeless on access, a poor level of funding and falling behind on some levels of treatment. It is completely the wrong way to go. If you want to put power in the right place, you don't move it sideways in Whitehall, you move it downwards from Whitehall.

Rt Hon. Patricia Hewitt

The Rt Hon. Patricia Hewitt is Labour Member of Parliament for Leicester West. She was Secretary of State for Health from 2005–07.

Ten years ago, people thought the NHS could not carry on. People were resorting to the private sector if they could afford it (and sometimes if they could not). Staff were demoralised and there was a real sense that the service was on its last legs, and we have changed that.

Now, no one is seriously challenging the idea of a health service that is chiefly funded through general taxation and free at the point of need. It is a real sign of the success of New Labour that it's unthinkable now for the Conservative Party even to put forward the idea of the 'patient passport' on which they fought the last General Election. They have had to come onto our ground, and say they are not looking at alternative means of funding the NHS – and that is for the first time in 60 years, which is quite something. We have won that argument. That is a very big change in the last 10 or 12 years, and it is absolutely worth celebrating.

The other thing about the 60th anniversary is the place of the NHS in the whole fabric of our society. It has got to be the best-loved institution in the UK. And that is worth celebrating when there probably isn't enough that binds us together.

Its biggest strength is its fairness: the fundamental principle that, if you need care, it is there and free at the point of need. It is not always as good as it should be, and it is not always as fair as it should be, but it is that sense of fairness that brings thousands of people into medicine and nursing and all the other professions within the NHS. And that makes the staff – for all the complaints they may have about specific aspects of the way the service is run – more committed and more motivated than in any other large organisation. The biggest weakness has been – with some very honourable exceptions – the failure of the service and the whole system to put the patient first.

Tony Blair's great insight was that we had to keep the ethos and values of the NHS while transforming the way it worked to match the expectations of a consumer age. I don't like the word 'consumer' for patients. But users of the service should expect to get the best and most efficient personal care that they would expect to get from the best organisations outside the NHS. Sometimes that does happen – it is happening more than it used to – but the whole system needs to be designed to do that.

That is why 18 weeks' [maximum waiting time] is so important. It is not just another national target, because what it is actually doing is driving a bottom-up redesign of the way the service works

in order to meet the target in ways that serve the individual patient well.

I remember talking to a receptionist in a West Midlands hospital's imaging department, who said that two years previously she would have to tell patients after they had seen the consultant that the wait for a scan was 18 months to two years. The steps from the GP [general practitioner] to imaging to operation was taking 200 hours of staff time. So they completely redesigned the system and slashed waiting times from 18 months to sometimes fewer than 18 days. They are now able to see and treat four or five patients in the time it previously took for one, with no extra money or staff, and this was done in the worst year of the financial problems.

That is what the 18 weeks target is doing, and I like to look at it as a 60th birthday present from the NHS to patients. For most patients, for most conditions, the waiting times that have dogged the NHS from the first year of its operation will largely have disappeared, and that is an extraordinary achievement.

Looking forward

Can it be sustained? There will always be innovation, but I think it is containable within a budget that will go on rising so long as the NHS

continues a constant quest for using the money better. That is the main reason why I was so passionate about improving productivity. I don't underestimate the pressures of technology, and when some terrific new drug becomes available, then everyone who could possibly benefit will want it immediately, and there is always going to be a tension there.

One of the most important things we did was the creation of NICE [National Institute for Health and Clinical Excellence]. You can't have politicians taking these decisions, and it is not sustainable in the modern world just to leave it to individual clinicians to decide in a very private way who gets what. Having an independent, clinically-led body to decide 'this drug for this class of patients, but not that one' is essential. But for that to remain sustainable, at least three things have to happen.

First, NICE has to be able to make its evaluations faster, which was the crucial thing we did in response to Herceptin – you get parallel processing, so that NICE is doing its work at the same time as the drug is licensed, instead of afterwards.

Second, we have to strengthen the public legitimacy of NICE. NICE has done an excellent job of involving members of the public, but there needs to be a real sense of open, visible, public engagement and transparency about these

decisions, so that people feel their voice is truly being heard – even if, in the end, it is a clinical judgement and not a matter for a vote.

Third, there has to be enough money available to fund most, if not all, of what people legitimately expect. If we get a huge gap opening up (and I don't think that we are) between funding and expectations, there will be a problem. If we did get to the position where NICE is recommending something and the NHS was saying it was unaffordable, and doctors were saying to their patients, 'You will benefit from this, but you can only have it if you go private', then you will get a new growth in private insurance and self-pay and once again that would threaten to undermine the NHS.

I do not think top-up fees are actually compatible with the ethos and values of the NHS. I do not see how you could run a cancer service within the NHS where some patients had been told by the consultant, "You really need this drug, or there is at least a limited chance that it may work for you, but you can only have it if you pay for it", and next door there is a patient with exactly the same clinical condition, and they cannot have the treatment because they cannot afford to pay for it. A degree of unfairness will always be there because some people will be able to go private entirely. But I don't think it is possible to allow that

sort of top-up within the NHS *and* maintain its ethos.

The NHS should use the independent sector, both private and not-for-profit, where it can help to give patients the best, and there are plenty of examples of that happening. GP practices have always been in the private sector, even though they don't like to define themselves that way – but it is true, they are.

Future challenges

When you look at one of the two or three biggest challenges facing every health service – long-term conditions, an ageing population and the lifestyles people adopt – it is essential that the NHS makes even better use of the not-for-profit sectors, social enterprises and self-help groups.

The other weakness of the NHS has been that despite Nye Bevan's vision of a service that would support people to be healthy, it has never really been able to do that. The sheer demands of illness and the urgency of the acute hospitals have always dominated the service's spending, policymaking, ministerial time and everything else. We still have a lot more to do to ensure that the NHS is as much a health service as an illness service. But we are in a better position to do that than we were, and a key contribution to that

was going smoke-free, which is really having a dramatic effect already on people's health.

People talk about the 'nanny state', but that is just a term of abuse that gets thrown at the Left. What we need is a much more focused understanding of how large-scale change happens, because clearly this is not only about government action. It is about quite deep and complex social change, where certain things that used to be accepted become rather unacceptable and strange. For example, there has been the most extraordinary change to attitudes to drink-driving. When I was learning to drive it was absolutely natural for people to offer you 'one for the road'. That was the norm. Now it absolutely isn't. Now that is partly the result of very tough laws and tough policing. But it has also been working with the industry and building the sense that you do not drink and drive, so that attitudes change.

So with the 'Five a Day' campaign on healthy eating, it was NHS-led but was built with the help of the supermarkets and the food industry, and the family expenditure survey last year showed for the first time that there was a marked rise in the purchase of fresh fruit. There is a long way to go – we need to be cleverer about making it happen.



RCN
**NO DELAY
IN
NURSES PAY**

**PAY
NURSES
NOW**

**NO
DELAY
IN
NURSES
PAY**

**PAY
NURSES
NOW**

**R.C.N.
IS YOUR N.H.S.
SAFE?**

**PAY
NURSES
NOW**

**R.C.N.
NURSES
AGAINST
THATCHER'S
CUTS**

**NURSES
DAY
OF
ACTION**

ACTION

IS Y

Increase attributed to sales to shop-floor workers
Record rise in health insurance

CHAPTER 2: SPEAKING TRUTH TO POWER

– GOVERNMENT ADVISERS AND SENIOR CIVIL SERVANTS

**fund NHS
post in child
cancer unit**

A CHILDREN'S cancer charity is donating £5,000 to keep a senior

By Nicholas Timmins

**new safeguards
for brain deaths**

**NHS ban on brand name
drugs for minor ailments**

**MPs told why
hospital beds
remain empty**

Timmins

**Doctors to
suggest
NHS drugs
bill cuts**

**'Millions wasted' on
tonsil operations**

From Nicholas Timmins

**Appeal likely over London
private hospital proposal**

Nicholas Timmins

An appeal to Mr Patrick
Spink, Secretary of State for
Social Services

The proposal, drawn up by
the special trustees of Univer-
sity College Hospital with help
from Private Practice

**Clarke says
79 NHS units
are applying
to opt out**

SEVENTY-NINE hospitals and

Sir Kenneth Stowe

Sir Kenneth Stowe was Permanent Secretary of the Department of Health and Social Security from 1981–87.

I don't think it has been 60 years of success. My concern about the National Health Service is: why is it so much poorer in so many respects than what has been done in Europe? Why are we where we are?

Your first response might well be to say, "Well, you were the Permanent Under-secretary and the Accounting Officer for six years, and what did you do about it?" Most of the time, you're plugging holes in dykes with a finger. In my six years, what stood out was the strike within the National Health Service (the biggest industrial dispute until Arthur Scargill beat it with the miners' strike). That demanded a great deal of attention, and we settled the strike on the basis that there will be a management enquiry for which I had to organise and recruit [Roy] Griffiths. That was down to me, and Norman Fowler said, "Deliver it. Who are we going to get?" I phoned up some of my chums, including John Sainsbury. He said, "Well, if you can get him, you want my deputy chairman, Roy Griffiths."

So I went along, without saying why I was going, for an interview with Roy Griffiths in his office in Stamford Street, and I spent the most uncomfortable 40 minutes of my career. He didn't

say a word. He just glowered at me while I was trying this way and that way to persuade him that this was an important job and he was the right person to do it. What I didn't know was that he had two children who were doctors – and that he was more than willing.

Then there were the consequences of Griffiths, implementing it. If that were not enough, we had the AIDS crisis, which led to an enormous diversion of both political and administrative effort, amid the business of keeping the show on the road year after year. On top of all that, you had the very, very real difficulty of directing – managing, in fact, is the word, and it really isn't but I can't think of a better – this vast, complex system of regions, districts, units, family practitioner committees; great complexity, all being run by a central authority. Allegedly, the minister supported by the Permanent Secretary who was the Accounting Officer, but obviously failing every managerial test that you can think of.

Sir Michael Edwardes,¹ whom I knew very well, said, "If the manager can't get his arms around the tree, then the tree is too big." Well, this was a tree that was much too big, and that did lead us to think.

The money was tight. One flaw in the structure that has now been remedied in part (but at a price) was the appalling consequence of funding

1. Chief Executive of British Leyland, 1977–82.

the capital programme from 1948 onwards as though it was all about new build. Every year, year on year, with one exception (the year of the International Monetary Fund crisis), the capital fund was bigger than the year before. It was a simple consequence of capital being a free gift: you spend it on new building, and then the new building looks after itself, or so it appeared – but, of course, it doesn't.

It wasn't until Patrick Jenkin initiated the inquiry carried out by Sir Idris Pugh² that it was clear that, on a conservative estimate, there was a backlog in the National Health Service estate of about £2 billion of maintenance – many times the quantum of the new capital investment. Now, that was a manifest managerial failure of very, very basic competence, but by the time it was being addressed it had gone on for more than 30 years.

Then there was the failure to take adequate account for an ageing population, the changing requirements of healthcare need, and the cost of medical advance. I was asked by Peter Hennessy when I was the Permanent Secretary, "If you were to meet Beveridge now, what would you say to him?" My reply was, "I would say to him: 'How did you get the figures so wrong?'" When the Queen Mother was born there were 5,000 90-year-olds, and a quarter of a million when she was 90. Now that didn't happen overnight. Antibiotics were already in place in the middle-

1940s; and the consequences of antibiotics, of eliminating the middle-age killers like pneumonia, must be that we get more old people. So there was a real failure to think things through.

Then there was the cost of medical advance. Terri Banks³ always tried to programme in a half of 1% increase in the cost of running the health service to allow for that. It never was clear where that figure came from; if we had asked for more we wouldn't have got it, and if we had not asked for that, it would have been a very bad move to assume that the cost of medical care was a constant.

It's the same everywhere. So there are going to be some very difficult decisions to take around priorities. But if you put round them a ring of steel which says the one thing that mustn't change is that everything has got to be free, then you have constrained the argument mightily. If everything hasn't got to be free, do you go into simple charging, or do you go into it by the back door, where you would have to have a model which doesn't actually offer you full compensation for the cost, but the bulk of it, and you either pay the rest yourself, or you insure yourself privately for the rest? There are many and various options for doing it.

Another failure was to follow the pre-1948 National Health Insurance pattern of linking the

2. Then President of the Royal Institute of Chartered Surveyors.

3. Senior civil servant in the Department of Health, Finance Division.

healthcare contribution to the social security contribution, so that healthcare was never properly funded. This is where we parted company with Europe, largely. A social insurance model would have had the advantages of ensuring that any deficiency in funding was apparent. There were ways of actually encouraging people to make provision for themselves, to contribute towards the cost of their care, social insurance reimbursing them for 80% or 90% of the cost with insurance available to cover the balance if you didn't think you'd be able to afford it.

I don't think what we've now got is viable. Caring for the aged is simply an exemplar of the whole problem. A lot of the care embraces both sides of the border between social care and clinical care. That might be the point of entry to having new thoughts about the whole system – the Trojan horse, if you like – and altering the funding of the NHS as you alter the funding of social care.

Patrick Jenkin, when he first became Secretary of State, and I inherited from my predecessor, Pat Nairne,⁴ the report which Terri Banks wrote about financing of the healthcare system, which raised all the issues that a sensible politician would not want to get near, and it was promptly buried under several inches of concrete. Norman Fowler scuppered it. Then I was approached by Sir Nigel Wicks.⁵ He commissioned a policy paper about

the future of the National Health Service, because it had become manifest that there was a problem. There was always too little money and there were always too many issues confronting ministers (you know the story, I don't have to elaborate). I and one of my deputy secretaries, Strachan Heppell, produced a paper which has never been released. That paper essentially drew attention to the two fundamental flaws in structure. First of all, the financing. There wasn't enough money, and what money there was came essentially from taxation, and all options for changing that in the past had been barely approached, and if approached, rejected. Second, there were the managerial problems which left ministers responsible for the management of a unit larger than the size of the Russian army. Each case was untenable, and the paper was really arguing a case for a fundamental rethink. There were no recommendations, simply that 'we cannot go on as we are, because it's not viable'.

I don't think Norman Fowler was especially pleased to receive this. It looked like trouble – and it was trouble, but it had been asked for by the highest authority. So we produced it, and it was sent to Mrs Thatcher. Norman Fowler and I had a meeting about it with Mrs Thatcher in her study at No. 10. She listened, we talked, and she listened, and we talked more, and she asked some questions. At the end of the meeting she turned

4. Permanent Secretary at the Department of Health and Social Security, 1975–81.

5. Stowe's later successor at No. 10 as Principal Private Secretary to Mrs Thatcher.

to me and said, “Ken, there is no constituency for change.” End of message. That paper was put away and I believe it might be surfacing in the National Archive in about 10 years’ time.

Shortly after that I left and Norman Fowler left, and John Moore⁶ arrived and walked straight into the bed crisis, all of which of course might have prompted me – had I still been there – to say, ‘I told you so, ma’am.’ It cost John Moore his political future.

I left immediately to become Chairman of Cancer Research and a trustee of the Cancer Research Campaign, and I’m still a founding trustee of Cancer Research UK, and one of its council. It’s that experience that brought home to me the appalling inadequacy of the system for dealing with particular kinds of acute conditions. I can’t begin to tell you the horrors that were then revealed about the inadequacy of cancer care throughout the UK. One that really rang home to me was when Tim McIlwain, who was a professor of medicine at the Institute of Cancer Research at the Royal Marsden Hospital, carried out his own investigation into the availability of a trained, qualified oncology surgeon to deal with a woman presenting at the hospital with symptoms of breast cancer. He found that in 40% of the hospitals in the country, there would not be a surgeon trained in dealing with breast cancer, it would be the province of the general surgeon – and that took a

long, long time to correct. Why? Undoubtedly the medical profession itself has a lot to answer for in the slowness with which it trained itself to absorb best practice. But equally the managerial system, what Roy Griffiths was trying to address, didn’t really focus on the deficiencies. One would see there was always this pressing demand to balance the budget. In the healthcare system that we’ve now got, you’ve got an enormous tanker which will respond very, very slowly to change.

The basic system remains. In certain areas, it can work very well. I don’t need to be convinced of that, because this past weekend my partner had to be taken urgently into a nearby hospital into the cardiac care unit, a small unit. I spent much of the weekend there. She’s now home. It was a Rolls-Royce operation. You could not fault it in terms of the quality of the kit they’ve got, the quality of the staff, the style, the approach, the care. Exemplary. But I could also tell you of the experience of her mother, in another hospital: she came out with a fractured shoulder, a bruised foot, gastroenteritis and a skin infection. So it embraces both the very best and the appalling worst of human healthcare. It’s not total imperfection, but there’s a lot that needs to be changed. Having thrown all this extra money at it, we still find we haven’t got enough.

The unforeseen failure of the implementation of the Griffiths report⁷ was that we had no medical

6. Secretary of State for Social Services (including health) from 1987–88.

7. Griffiths R. *NHS Management Inquiry*. London: Department of Health and Social Security, 1983.

chief executives. We had one consultant who was prepared to take on the role of chief executive in a hospital, but that was not what we wanted. It was intended to put medical leadership in a position where it would take total responsibility – as used to be the case – of having a medical director in charge of a hospital. But the best consultants and doctors would have spent their life working to very high levels of dedication and expertise and efficiency in their specialty, and they would see that as being thrown away if they then took on the responsibility for the hospital. That attitude does not prevail in other countries. It's part of the British disease; one part of which is that we don't care, and don't know, about what goes on in the rest of the world.

Why did it take so long for it to be understood that in the 200 or so district general hospitals that were created as part of the Enoch Powell plan, that we needed an oncology department to deal with the increasing incidents of cancer patients, and they needed to be trained and that there were places where they could be trained? It says it all. There is a failure of medical leadership. I suppose it's part of their love-hate relationship with the healthcare system. I don't know, it could have been theirs, but it wasn't.

My basic point is that 60 years of celebration is fine. Yes, we're still here. But the deficiencies that

are there already are of concern – and looking ahead, which we've not been very good at, it's going to get much, much worse.

Clive Smee

Clive Smee was Chief Economic Adviser at the Department of Health from 1984–2002 and was the Queen Mother Memorial Fellow at the Nuffield Trust 2003–04.

In 1994, in its regular survey of the UK economy, the Organisation for Economic Cooperation and Development (OECD) stated that the NHS “was and is a remarkably cost-effective institution”.¹ Most national and international policy analysts probably concurred. Analysts in the Department of Health certainly did.² Six years later, in its next major review of UK healthcare, the OECD came to a radically different conclusion. The 2000 study highlighted the poor cancer survival rates in the UK, suggested that other disease-specific outcomes were also poor, and noted the limited progress on waiting times and the apparent under-investment in both doctors and buildings. Instead of drawing attention to the efficiency of the NHS, it drew the conclusion that the NHS was underfunded.³ Many officials and politicians in the UK had reached a similar conclusion. On 16 January 2000, while the OECD report was still in draft, the prime minister made his seminal commitment to match the average health expenditure levels of the European Union by 2006/07.

Why was the reputation of the NHS so high among international policy analysts in 1994, why it had fallen so far by 2000, and what does this rapid change tell us about international reputations in healthcare?

Internationally, the NHS has always enjoyed a reputation for equity in financing, largely free access to care and tough budget controls. In the first half of the 1990s the available OECD statistics also suggested that it used resources more intensively than most other countries. For example, average lengths of stay in acute care were among the lowest in the OECD, bed turnover rates were the highest, and doctor caseloads appeared to be at the top of the international distribution. Moreover, on these kinds of indicators not only was the NHS more efficient than other health systems, but its efficiency looked to be improving faster. This high and improving level of efficiency appeared to explain why a country that devoted a lower share of its gross domestic product (GDP) to healthcare than any other country in Western Europe (except Luxembourg) was able to achieve levels of health status – used as proxies for healthcare outcomes, in the absence of any such measures – that were in the middle of the OECD range.

1. Organisation for Economic Cooperation and Development (OECD). *OECD Economic Surveys 1993–4: United Kingdom*. Paris: OECD, 1994.

2. See, for example, Smee C. *Speaking Truth to Power. Two Decades of Analysis in the Department of Health*. Oxford: Radcliffe, 2005, ch. 5.

3. OECD. *OECD Economic Surveys 2000: United Kingdom*. Paris: OECD, 2000. In private the authors went further and indicated they had been unable to identify any features of the NHS that were particularly commendable.

The Thatcher government's internal market reforms further increased the attractiveness of the NHS to policymakers in other countries. For many countries hard-pressed to control expenditure, the reforms looked to offer new ways of increasing efficiency. The reforms attracted particular attention from countries with predominantly tax-funded healthcare systems, such as Sweden and New Zealand, and from countries just emerging from the former Eastern bloc. The Department of Health was invited to send advisers to countries as diverse as New Zealand and Russia, including a 10-man team to Poland. There were high-level study tours of the UK from other countries including Germany, Sweden and the USA. The emphasis on market forces and incentives also appealed to the dominant economic philosophy in the OECD secretariat – doubtless, this contributed to the plaudits in the 1994 report. From other countries including Australia and the USA there was envy and/or admiration for the size and speed of change that appeared to be possible in the UK's highly centralised healthcare system. On international trips, Department ministers were delighted to bask in the interest and compliments of their foreign counterparts.

Given the international composition of the OECD review team and the process by which country reviews are carried out, it is reasonable to assume that the conclusions reached in 2000 were

consistent with the views of many other overseas policy analysts. So, what had changed?

First, there had been major changes in information. The arrival of comparative cancer survival rates, showing the UK towards the bottom of the international distribution, shattered the assumption that health status measures were a good proxy for measures of quality of healthcare. The NHS could no longer be confident that its outcomes were middle of the road, and other countries had good reason for becoming more sceptical about its performance. In addition, the evidence of outstanding efficiency was more directly undermined: the Department discovered that the data it was supplying to the OECD on hospital admissions and length of stay were not consistent with the data being supplied by other countries. More particularly, by providing data on finished consultant episodes rather than hospital spells, and by adding together day-cases and overnight admissions, the UK appeared to be achieving lower average lengths of stay, higher bed turnover rates and higher admissions than was actually the case. Correcting for these definitional differences, the UK's technical efficiency was still relatively good, but it was no longer outstanding.

Second, the internal market reforms had not produced the scale of benefits that many had

anticipated. Despite an initial jump in measured efficiency, the pace of change had been slowed down already by the Conservatives before the internal market was formally abolished by Labour in 1997. The new policy emphasis on targets and central performance management was not so attractive to health systems which historically either relied more heavily on decentralisation (most of Western Europe and Australasia), or were trying to escape the centralised policies of the past (most of Eastern Europe).

Third, there had been a slowdown in the growth of public expenditure on the NHS at the same time as public expectations of health services appeared to accelerate. Fuelled perhaps by rising standards expected in other service industries, countries which previously had seen UK hospital waiting times as a local idiosyncrasy now regarded them as a clear sign of failed policies, particularly of underfunding.

If these assessments by the OECD can be taken as markers for the international reputation of the NHS, at least among policy analysts, several conclusions may be drawn. First, the international reputations of health services can change very rapidly, almost certainly more quickly than the real experience of patients. More recent assessments by The Commonwealth Fund reinforce this message: in the Fund's well-informed comparisons

of six healthcare systems (Australia, Canada, Germany, New Zealand, the UK and the USA), the UK's position rose from third in 2006 to first in 2007.⁴

Second, despite the best efforts of the OECD and the World Health Organization, the information base for comparing national health systems remains poor. Indicative of the difficulties is that it has taken the OECD six years of work to publish a first set of indicators of quality of medical care.⁵ Even then, these cover only 11 conditions. Robust comparisons of safety and responsiveness to patient needs and expectations remain awaited.

Third, relative national rankings (and the reputations that they influence or reflect) are highly sensitive to the values of those making the assessments. For example, many Americans would probably argue that Commonwealth Fund rankings unfairly disadvantage the USA, because they attach as much weight to equity as to 'right care' or to the timeliness of care, and none at all to choice.

Fourth, overall reputations can be a poor guide to the treatment provided for a particular condition or disease, and vice versa. The 2007 OECD indicators of quality of medical care show the UK as 18th out of 24 countries in terms of in-hospital deaths within 30 days of a heart attack.

4. Davis K., Schoen C., Schoenbaum S.C., Doty M.M., Holmgren A.L., Kriss J.L., Shea K.K. *Mirror, Mirror on the Wall. An International Update on the Comparative Performance of American Healthcare*. New York: The Commonwealth Fund, 2007.

5. OECD. *Health at a Glance 2007: OECD Indicators*. Paris: OECD, 2007.

However, on the same measure after an ischaemic or haemorrhagic stroke, the UK is second and third best respectively. As measures of quality of medical care expand it will no longer be defensible to use a poor record on one disease, even a cancer or hospital-acquired infection, to berate a whole healthcare system.

Sir Duncan Nichol

Professor Sir Duncan Nichol, CBE, is a non-executive director of the Christie Hospital, Manchester and Chairman of HM Courts Service Board. He was Chief Executive of the NHS Management Executive from 1989–94.

At the risk of sounding cheesy and a bit hackneyed, the fact that we have a health service that provides, to all intents and purposes, universal cover and universal access is – well, we take it for granted, almost – some deal.

In recent times – and I would tend to link this to the arrival of the internal market – we have achieved some important cultural changes: for example, the primacy of primary care, the increased cost-awareness within the service, more clarity around standards and the fact that people have to be accountable for them. The combination of the founding principles and some of those cultural changes are fantastic achievements. A system that pools the risk through taxable revenues is hard to beat.

There is an issue about what has happened with all the recent big investment. Rightly or wrongly, the Government seemed to be chasing the average of European spending on health as a share of GDP [gross domestic product]. But the European average was always a mix of public and

private spending, and what we were aiming at was never spelled out clearly.

For that kind of investment you were, I think, looking for a serious return in terms of clinical progress, clinical outcomes. It's always going to be extremely difficult to link the two. But the sense that we squandered some of that investment down a black hole – not least the deals that were done with consultants and GPs [general practitioners] – is, I think, a sadness. The investment should have reaped more obvious returns. People should have been able to measure and to evaluate and say, 'Look what we've achieved clinically', and not look at what we've wasted down the drain of the salary route. Disappointing.

The whole arena of 'beefing up' risk-adjusted information on clinical outcomes is one of the big issues. Maybe there is a fear of not wanting to open Pandora's Box, that it felt a little like harassment and public hanging, and entering a no-go area of autonomous clinical practice. It is a difficult door to prise open, and it's been slow to develop, but it needs to be opened.

I do think we should have gone more boldly for competition in both primary and secondary care. There has been some ambiguity and ambivalence about using the private sector on the supply-side.

I think it will go further. There has been a gradual erosion of the boundaries, and I think there will be more.

On the financing side I think that whatever increase in spending you've got, most health services in the developed world include some form of cost-sharing. Now, whether that's out-of-pocket deductibles, whether it's voluntary insurance, whether that voluntary insurance is mainly supplemental, or whether it's substitute, whether it's more likely to be angled towards long-term care, rehabilitation, the cost of medicines, dentistry, home care... well, I think it will increasingly include bigger contributions from out-of-pocket and voluntary insurance.

I'm well aware of the debate about diabetes and chronic illness, and how can you possibly have people not exempt from out-of-pocket or any form of contribution when they are chronically dependent. But stepping back from that, I think there should be some form of voluntary insurance or out-of-pocket expense. I think people need to understand the cost, need to understand the value that they're getting, and there needs to be some disincentive for abuse – not in the sense that people abuse it because it is free, but that, particularly at the primary care level, whether they think hard enough about whether they need to trouble the service. It is a tough one, but I think

we should explore it. I used to be on the board of Bupa. How many people take advantage of that? I think it's 10% still.

There is a lot of talk at the moment about reforming the way social care is funded – about whether there should be some sort of voluntary supplemental contribution at a time in your working life when you can afford to make it, where you've been incentivised by the state to make it. The deal is that government can't pay for everything in social care, and you're giving yourself an extra cover. I think that's sensible. The boundary between health and social care is such a fine line, such a permeable boundary, that the debate about social care may get you into the debate about the funding of NHS care.

In terms of managing the service, I think we run a service which on the whole controls the cash pretty well, irrespective of whether we were getting good settlements or less good settlements. But I don't think it's been at its best in extracting value for money, which is a key management issue. It has not been good at rewarding success and, more particularly, in dealing with failure, and that applies to both primary care trusts and providers.

I do think we need to be more ambitious about rewarding clinical teams so that they feel more

ownership of the organisation they work for. If they've got more of a say, not just in how it's being managed and the key decisions being made, but if they've got a sense of 'try harder, do better and there's something in it for you – and beware, because there will be sanctions if you're falling off the other end'.

It is partly a Treasury problem: their sense is that, if there's any money around that's being saved through efficiency and effectiveness, why don't we just bank it? We don't have to share it, do we, to get more of it? So, I think there's a real problem in investing to get a return, whether it be capital investment or whether it be human capital investment. There's a sense that we don't have to do this because we can just squeeze them so hard and give them tough targets, and they're going to deliver.

Well, yes, of course people deliver. I mean, they take the Queen's Shilling when they join the National Health Service, but this is not in tune, in my view, with the way people respond in some of the companies that I've been involved in, which are not all for-profit – some of them are not-for-profit. It is not just financial in the sense of take-home pay. Professional staff are also in for the opportunity to develop their service, their professional team and professional education and their research and all the rest of it, our research.

A recognition of the job I do would be that I am allowed to invest in new technology when it's been proven to be effective, as opposed to be generally obstructed. There are ways of giving public recognition and reward, including financial, to those who give us more than others. So the question is: when do we get serious about incentives and sanctions?

The other point I would want to raise is about the clinician's role. Most people go into clinical training to provide direct patient care. But when we've engaged doctors in designing and leading the strategic development of services, when we've encouraged them to understand the economics of health, when we've encouraged them to develop (as in cancer) risk-adjusted benchmarking, then we've got a much better service. The change which puts the clinician in a key role – clinical budgeting, if you like, which kicked off with Ian Mills – is a good investment. It is one hell of an idea and we still don't do enough to develop this potential.

You say to me that one of the service's greatest weaknesses has been almost the abdication by the medical profession of the managerial role in medicine – and we are unusual, compared to other countries. If you have an MBA in the States and you're a doctor, people think, well, you're a sharp guy. Here they think, well, you're a grubby

businessman, a bit of a quisling, and it's beneath you. The medical profession in this country kind of abdicated its leadership role in management to managers, and then bitched about the result and disengaged. Well, you say that, and I agree with that absolutely. If we can rebuild the clinical role in management, that will produce happier doctors, because they will be shaping the agenda; and it will produce better outcomes for patients, partly because there are certain things that doctors can do that managers can't.

There has been some improvement in recent years, and I am encouraged by that. But it is an uphill struggle. I've just rejoined the NHS as a non-executive [director] at the Christie Hospital, and the clinicians in leading positions there (in a foundation trust) are fantastic people who are pitching in – and that's in a hospital where traditionally there was a big distance between the manager and the clinician. I've really enjoyed going back and seeing that. It really made me feel good.

This was a key aim of the Griffiths report:¹ not just managers, but medical managers. We got some of them into it then – not enough – and some of them were good at it. A number of my managerial colleagues at the time thought, 'We're going to be out of a job here.' My position was, 'I don't have a problem with that.' But the momentum

got lost. It was long overdue when it happened and I helped get the British Association of Medical Managers off the ground, because I thought it was important. It is desperately needed that we get back to that agenda.

1. Griffiths R. *NHS Management Inquiry*. London: Department of Health and Social Security, 1983.

Sir Graham Hart

Sir Graham Hart, KCB, was Permanent Secretary of the Department of Health from 1992–97.

The NHS has proved to be the most enduring achievement of the 1945–51 government. Essentially, the principles on which it was built – that it should be comprehensive, available to all on the basis of clinical need, free at the point of use and funded by the taxpayer – remain in force today. Although the service has its problems, it still enjoys justifiably high levels of public support. The public want it to be better – they do not want a different system.

Keeping the service going through the last 60 years has not been easy. Right from the start, money has been a problem. The way we fund the NHS raises two linked issues. First, the service, which for many reasons grows increasingly costly, has to be paid for from taxation, and politicians dislike raising taxes almost as much as the public dislike paying them. For 15 years or so I was involved in the annual public expenditure negotiations between the Department of Health and the Treasury. Often the outcome fell below what was needed. We scraped by, but by the 1990s it was easy to be pessimistic about the future of the NHS, to think that unless we could find a way of getting significantly more money out of the existing system, the service would become unsustainable and a completely different system,

probably depending heavily on charges and private insurance, would have to be substituted.

Second, since ministers who spend public money must account for it, the consequence of the NHS financing system is that ministers must accept responsibility for the service. When Aneurin Bevan created the NHS, he recognised the problem and tried to devolve as much responsibility as possible to regional and local bodies, but over the last 60 years the tendency has been for increasing central involvement and direction. Given the huge increase in media and public interest in the NHS, this centralising tendency seems largely unavoidable. I well remember one Secretary of State telling his officials firmly that he would not get involved in an industrial dispute in the NHS, since this would politicise the matter; the next day, media pressure got him in the thick of it.

People often talk of the NHS as though it is a huge monolithic organisation (comparisons with the Red Army and the Indian State Railways abound). This is a misleading model. The NHS comprises more than 1 million staff, mostly professionals providing individual services to millions of patients according to professional standards. It cannot be run from Whitehall in any detailed way. This has been recognised increasingly in recent years and there has been much discussion about how decisions can be decentralised.

While it is possible to envisage some minor changes in the way that ministers interact with the NHS, no one yet has come up with a convincing plan that would combine public financing with freedom from detailed ministerial involvement. Politicians worry that an independent NHS board or commission would quickly become a pressure group for more resources; more probably, it would be little more than an extension of the Department of Health. True democratic control at local level, which would make a difference, would need at least a degree of local funding and would be bitterly opposed by important interests in the service.

So, in short, we have had for 60 years an NHS funding system which necessarily forges an indissoluble relationship between the service and the politicians and civil servants in Whitehall. To escape from, or seriously dilute, the relationship would require a fundamental change to a new system of funding which relies much more heavily on non-state sources. Possibly, this might produce a more generous flow of funds; however, it might not – and the difficulties in ensuring reasonable access for all and obtaining political agreement on such a totally new system would be truly formidable.

It seems likely that the present system, imperfect though it is, will have to stay in place, and we

should not overlook the advantages of the present arrangements for the NHS. One such benefit is security: although the funding of the service may feel inadequate, it is secure. The paymaster may be tight-fisted, but he certainly is not going bust. Neither should we forget the importance of what happened on breakfast television in January 2000. Tony Blair announced that the Government would increase NHS spending until the UK reached the European Union average. This was the most startling political intervention in the NHS since Mrs Thatcher's 1987 announcement (also on television) that the NHS was under review, a process which also led to some very important and enduring changes.

Blair's announcement has produced the fastest rate of growth ever in NHS spending and has done much to make good the previous short funding of the service. It seems hard to envisage that governments will be able to ditch the commitment.

These two very important announcements by prime ministers were both personal initiatives, clearly motivated by a sense that the NHS was in difficulty and that ministers had to take a strong lead to show that they were living up to their responsibilities. (It is an interesting reflection on the processes of government that in neither case had these very important decisions been

reflected in the relevant party's election manifesto, discussed beforehand by the Cabinet or indeed even with the Secretary of State for Health.)

The NHS has become, and will remain, high politics. It is one of the top issues for any government when the polls come around. This means that ministers will continue to play an important part in the policy and management of the NHS, but also that they cannot ignore its problems and must provide reasonable levels of funding. Their success is tied to that of the NHS.

Sir Alan Langlands

Sir Alan Langlands is the Principal and Vice-Chancellor of the University of Dundee, and former Chief Executive of the NHS Executive from 1994–2000. He is a trustee of The Nuffield Trust.

For 60 years, the real strength of the NHS has been clarity and constancy of purpose. In essence, the purpose of the NHS is to secure through the resources available the greatest possible improvement in the physical and mental health of people by:

- promoting health
- preventing ill-health
- diagnosing and treating injury and disease, and
- caring for those with long-term illness and disability who need the services of the NHS.

This statement of purpose has wide public acceptance and commitment to it induces more than 1 million staff to get up at all hours of the day and night, 365 days a year, to work in the NHS. The aim is still to provide services on the basis of equal access for equal need, not the ability to pay, and while this is always going to be difficult to achieve in practice, political consensus around this principle is now stronger than it has been at many points over the past 60 years.

The NHS and other health systems across the developed world face many challenges: the call for

more personal care, the need to harness scientific and technological advance, the requirement to reshape services to meet demand and changes in the burden of disease are the most significant. Measuring progress is notoriously difficult but there are – and always have been – three key results at the heart of the NHS:

- equity – improving the health of the population as a whole and reducing variations in health status by targeting resources where needs are greatest
- efficiency – providing patients with treatment and care that is both effective and good value for money, and
- responsiveness – meeting the needs and wishes of the individual people who use the NHS.

Achieving progress against each of these results is a huge challenge in itself, with the health gap between rich and poor proving to be particularly stubborn, but of course, all three are interlinked. A great deal of NHS decision-making, from the clinic to Richmond House, is about finding trade-offs and compromises between them.

The answer to these challenges does not lie in further organisational upheaval (which will simply drain energy and purpose from the NHS), or in slavish adherence to or outright rejection of the current change programme. The intricate *gavotte* between the policies of choice, markets,

regulation and targets is difficult to follow in the abstract, but there is growing evidence that these policies might be refined, calibrated and applied differentially to tackle key issues such as quality improvement,¹ the management of chronic illness² and the use of the Quality and Outcomes Framework to treat risk factors in primary care.³ The NHS is at its best when it is being pragmatic.

Against this background, one of the main leadership tasks is complexity reduction – translating policy into workable (and understandable) rules for the management and financial stewardship of the NHS, ensuring a coherent approach to quality improvement, information management, the development and motivation of staff and the entry and diffusion of new technologies. Skilful handling of these issues will be essential as the NHS descends from the dizzy heights of 7.4% growth to the historic norm of about 3%.

References to the scientific and technological basis of health services will have irritated the policy purists, but this stuff matters and it is an area where the UK has the potential to provide international leadership, contributing towards biomedical innovation, advances in healthcare and the protection of the public's health. The relationship between science and health services

has had a chequered history over the past 60 years, but the signs are now better than ever.

The National Health Service Act 1946 made provision for ministers to “conduct, or assist by grants or otherwise any person to conduct, research into any matters relating to the causation, prevention, diagnosis or treatment of illness or mental defectiveness”. Despite this early encouragement, the reality was very different – the lion's share of research funding was channelled through the Medical Research Council to its own institutes and the undergraduate and postgraduate teaching hospitals. However, its primary job, which it did extremely well, was to understand the mechanisms of disease and produce new treatments, not to worry about the effectiveness of the new treatments or their implementation. The medical charities and pharmaceutical companies also did their bit, but the NHS kept its distance.

The first sign of real change came in 1988, when the House of Lords Select Committee on Science and Technology⁴ observed that the NHS had almost no research capability of its own. Heady progress was made between 1990 and 1995, with the appointment of Sir Michael Peckham as the first NHS research and development (R&D) director, the publication of *Research for*

1. Leatherman S., Sutherland K. *The Quest for Quality: Refining the NHS Reforms*. London: The Nuffield Trust, 2008.

2. Dixon J. Critical Essay: Improving Management of Chronic Illness in the National Health Service: Better Incentives Are the Key. *Chronic Illness* 2007; 3: 181–93.

3. Guthrie B., Inkster M., Fahey T. Tackling Therapeutic Inertia: Role of Treatment Data in Quality Indicators. *British Medical Journal* 2007; 335: 542–4.

4. House of Lords Select Committee on Science and Technology. *Priorities in Medical Research*. London: HMSO, 1988.

Health,⁵ the promise of spending 1.5% of the total NHS budget on R&D, new infrastructure developments such as the Health Technology Assessment Programme and the Cochrane Centre and improved relationships with research councils, the European Community, industry and other government departments. A bold start, which in 1995 saw 1,000 people from 40 countries converging on London for the NHS's first conference on the scientific basis of health services.

It was at this conference that Professor Tony Culyer – then an economist at York University – predicted that the R&D journey might fail to win the hearts and minds of policymakers, and so it proved. The new Congress in the USA was boosting basic scientific research and cutting back on evaluative research, and the same happened here – the 1.5% target was never reached, although basic science continued to grow in strength, largely through the generosity of the biomedical charities and determined government action on science and innovation. The result is a number of powerful new approaches to diagnosing and treating illness and disease, including the discovery and validation of new biomarkers of disease, advances in imaging, the development of new chemical compounds, biopharmaceuticals and molecular medicines and the prospect of successful gene therapies and cell replacement therapy using stem

cells. The need to close the gap between science and health services has never been greater, and the health and economic benefits of doing so, never more inviting.

Sir David Cooksey's *Review of UK Health Research Funding* published in 2006⁶ was comprehensive, identifying the need for an overarching UK health research strategy and the requirement to close two key gaps in the translation of health research: translating ideas from basic and clinical research into the development of new products and approaches; and incorporating those new products and approaches into clinical practice.

Cooksey also echoed Derek Wanless⁷ in highlighting the importance of the 'Connecting for Health' programme in promoting integrated care and (subject to stringent data protection and patient confidentiality safeguards) supporting biomedical innovation, clinical research and major population studies. The Darzi review, if it follows his formula for London – localise where possible, centralise where necessary and work towards greater integration of care – will be heavily dependent on improving information management and technology.

The Westminster Government's response to Cooksey, which has support in Scotland and Wales, has been quick and incisive. It builds on

5. Department of Health. *Research for Health*. London: Department of Health, 1993.

6. Cooksey D. *A Review of UK Health Research Funding*. London: HMSO, 2006.

7. Wanless D. *Securing our Future Health: Taking a Long-Term View*. London: HM Treasury, 2002.

the Medical Research Council's critical strengths in basic research, the development of the National Institute for Health Research,⁸ which has the remit of reforming the NHS contribution to health research, and the positive influence of the UK Clinical Research Collaboration, which has prompted significant improvements in the infrastructure for research at the interface between universities and the NHS. Critically, it includes a commitment to increase health research funding to almost £1.7 billion a year by 2010–11 (comprising £682 million for the Medical Research Council and a ring-fenced sum of £992 million for the National Institute for Health Research), and a new system of coordinated working under the aegis of the Office for Strategic Coordination of Health Research, focusing on translational medicine, public health and e-health.

Finally, after 60 years, the NHS has ended its casual relationship with science and technology. The opportunity to translate basic and clinical research into local, national and global therapeutic and healthcare benefits, and to link information from a wide range of medical and non-medical sources using electronic patient records to ensure better treatments, improve patient safety and advance medical research, are opportunities which must not be squandered. The historic purpose of the NHS is as relevant today as it has always been, and while many of the existing challenges will endure, the integrated health research

strategy should provide a new foundation for soundly-based clinical and managerial practice. Set alongside the intelligent application of existing policies, it also might refresh and rejuvenate the NHS as it celebrates its 60th birthday.

8. National Institute for Health Research. *Transforming Health Research*. London: Central Office of Information, 2008.

Simon Stevens

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I started work for the NHS on its 40th anniversary, in one of its friendlier backwaters. Following the demise of the steelworks, Shotley Bridge General Hospital had become the largest employer in Consett. Former Durham steelworkers and miners could be found working in the previously women-only hospital laundry. Patients with dementia were treated to ‘reality orientation’ sessions featuring photos of the now unreal steelworks. Porters struggled to push patients from operating theatres to Nissan hut wards up a steep open-air hillside. The senior surgeon only had one eye.

Nye Bevan may have felt he “would rather be kept alive in the efficient if cold altruism of a large hospital than expire in a gush of warm sympathy in a small one”,¹ but I am not sure the people of Consett agreed. This was healthcare of the people, by the people, for the people – a hospital serving its local community, staffed by its local community and of which the local community was unswervingly proud.

For many people, this portrait-in-miniature captures the NHS’s greatest achievement: namely,

its embodiment of the principle “from each according to their ability, to each according to their need”. This is seen as both the assertion of a moral value judgement about how healthcare should be allocated, and a statement about the psychological reassurance of knowing that healthcare will be there “when you or your family need it”. On both these tests, the NHS has to be judged as highly successful compared to what predated it in 1948, and reasonably successful compared to other industrialised countries.

However, these are not the only criteria by which to judge a high-performing health system. With hindsight it is clear that for much of the post-war period we mistook ‘cheap’ for ‘efficient’, ‘tax-funded’ for ‘equitable’, and ‘universal’ for ‘responsive’. Relative to what we could have afforded as a nation, we spent too little on healthcare and rationed too much. The NHS failed to challenge persistent inequalities in the availability and quality of primary care in poorer communities, partly by opting for a quiet life and taking a hands-off approach to the inherited small-business model of general practice. And by accepting the nostrum that the health service existed only to meet professionally defined health needs rather than patient-expressed preferences, the NHS came perilously close to inducing the sort of middle-class flight that has caused the social stratification of inner-city state education.

1. Reported in Hansard, 30 April 1946, quoted in Timmins, N. *The Five Giants: A Biography of the Welfare State*. London: HarperCollins, 1995.

Underpinning these weaknesses was the NHS's tendency to undergo extended periods of stasis, followed by periodic crises and then the next 'great leap forward'. Too often throughout its history, the crises were the predictable consequence of several years of anaemic funding increases. Also, too often the subsequent great leap forward comprised reform by proxy, as managerial reorganisations merely scratched the surface of the NHS's underlying clinical performance challenges.

So while successive governments (and perhaps the tax financing mechanism itself) must shoulder blame for the stop-go nature of NHS funding over its six decades, vested interests within the health service share responsibility for the fact that frequently only a crisis could impel and legitimate needed reform. Take just three examples from the past decade. It was the Mavis Skeet cancer case in winter 1999 that led to Tony Blair's decision to raise UK health spending to the European average, not Derek Wanless' elegant rationalisation two years later. It was the Bristol Royal Infirmary scandal that was the pivot on which the professions finally were forced to accept more transparency in clinical performance, and at least some external quality inspection. It was the public storm over bodies in the Bedford Hospital mortuary that produced autonomous foundation hospitals in place of NHS hospitals directly

answerable to the Health Secretary, and for which he in turn answered directly to the House of Commons.

Yet it is also easy to forget that a number of the threats that seemed likely to overwhelm the NHS have been overcome. All three political parties now profess to support the NHS's extra tax funding, and to believe that it can be used to square the circle between collective solidarity in financing and more individual responsiveness in care delivery. Most of the health reforms of the past decade have entered the political mainstream – no party is proposing overturning the key building blocks. Also, the once all-consuming 'rationing' debate mostly has abated. None of which, of course, is enough to satisfy all critics. Indeed, to the many achievements of the NHS at 60 must be added its ability to rise above a persistently negative background noise, generated by three rather different groups proclaiming its imminent demise: the 'dystopians', the 'romantics' and the 'payroll pessimists'.

For the dystopians, the grass is always greener in some other country's healthcare system. For them the mystery is why the NHS, with its manifold failings in theory, has survived in practice. For different reasons, the (Millenarian) romantics also believe that the end of the NHS is always nigh. This group conjures up an unspecified time before

the rot set in, which is then juxtaposed with the latest proof of how the elected government of the day has surrendered to the impending ravages of capitalism. So back in the 1970s and 1980s, NHS pay beds were destroying the NHS, Whitley Councils were destroying the NHS, in the 1990s it was NHS trusts and the purchaser–provider split that would destroy the NHS, then a decade later foundation trusts and patient choice, and so on in an unending sequence of fresh outrages – each allegedly heralding the end, until quietly forgotten a year or two later.

However, more than the dystopians and the romantics, it is the third group of naysayers which has tended to have more influence on public opinion: the payroll pessimists. These are the staff groups and health unions for whom morale is said to be ‘at its lowest ever’ each year. Of course, statements such as this are common across large swathes of the public sector and in many countries’ healthcare systems, deployed as a tool to raise pay and see off perceived threats to professional autonomy. Indeed, as one Canadian commentator has pointed out, one of the key differences between private and public-sector organisations is that the private sector secures more resources from customers by describing how well it is performing, whereas the public sector attempts to get more resources from voters by complaining how poorly it is doing.

This points to perhaps one of the bigger threats to the NHS over the coming decade: that as the rate of NHS growth again slows and NHS pay is dampened somewhat, staff groups ‘overshoot’ in their public campaigning. In so doing they inadvertently could persuade a critical mass of voters that despite the vast increases in tax funding, the NHS is not providing (and cannot) decent, high-quality care. Should such a belief ever take hold, the political process could give rise to a new healthcare funding dispensation that would break with key tenets of the 1948 settlement.

There are other threats, of course. The performance of the UK economy is the best predictor of what we will be able to afford to spend on the NHS. If it does poorly, once again the gap between NHS funding and new technology could open up to politically unsustainable levels, although the rather weak pipelines of the major research-based pharmaceutical companies may mean that this is less of a challenge over the next few years than it has been at points in the NHS’s past. Greater public awareness of variation in the quality and safety of NHS care – be it stroke services or MRSA – will undermine the psychological reassurance that the NHS is supposed to provide, unless the various new quality improvement mechanisms become more effective. The NHS will be able to manage demand while being consumer-responsive only if, for

the first time in its history, it gets serious about commissioning, about influencing health-related individual lifestyle choices, and about supporting self-care, informal care and social care.

So to survive, the NHS will need to continually reinvent itself, as it has been doing since 1948, just like all the most durable British institutions – parliament, monarchy, BBC and Marks & Spencer. Personally, I hope and believe that it can do so, so that a decade from now it will be in rude health, alive and kicking and celebrating its three score years and ten.

Lord Nigel Crisp

Lord Nigel Crisp, KCB, Baron of Eaglescliffe, was Chief Executive of the NHS and Permanent Secretary at the Department of Health from 2000–06.

Looking back over my 20 years in the NHS I am struck by how it has retained the ability to inspire and motivate new generations of young people to want to work in healthcare. It has provided, and still provides, the vehicle to express their idealism and hopes for society and to work towards their personal dreams and ambitions. At the same time, the NHS has maintained its focus on meeting the health needs of the whole population and sought to deliver care equitably to everyone in the country. For example, this has been reinforced in recent years with some redistribution of resources from south to north, so that the poorest parts of England now receive almost twice the funding of the wealthiest.

International comparisons show that the NHS is still among the fairest systems worldwide, with its services accessible to all parts of society. However, the most frustrating aspect of recent years is the way in which the NHS has found it so difficult to jettison the habits of 60 years ago and adapt its practice and behaviours to today's very different environment.

Other sectors, institutions and industries have faced similar problems in becoming more

responsive to their public and their customers, and catering for a more individualistic society in which people are wealthier and have higher expectations of the products and services they receive. The NHS, with all its complexities and cross-currents, is finding this transition harder and longer than most. It has still some way to go before it reaches a new status quo, responsive to its public and confident in its quality and its place in society.

The difficulties of this continuing process of adaptation have damaged the NHS's reputation and shaken public confidence. Despite this, there are reasons to be optimistic about the future. There are positive features in both the internal and external environments. Internally, new structures and processes are becoming embedded. Nationally, there appears to be greater agreement on policy across political parties, with the prospect of greater stability and clarity of direction. Further afield, there is evidence of new trends in international thinking.

I have heard people in Africa and America say that what they want in their country is a system which is designed to address the needs of the whole population, where there is a national framework of standards, and where services are delivered by a mix of public, private and not-for-profit providers. If this really is an emerging model for the future, the English NHS is ahead of the game.

Foundation trusts and primary care trusts, the twin organisational pillars of the new NHS, are maturing and beginning to make an impact locally, and will do so nationally in due course. On the one hand, foundation trusts, locally governed and profitable but not-for-profit, have the freedom and motivation to design new services, make new alliances, apply quality standards rigorously and develop service-orientated research. On the other hand, innovative primary care organisations, working to meet the needs of their local population, have the potential to create more responsive services, challenge the dominance of the acute sector and improve services for the hard-to-reach parts of their population.

However, there is unfinished business. These far-reaching changes have not been matched by equally powerful innovations in public health, or in the links between health and social care. Policies and mechanisms for tackling obesity, for example, remain poor, while there has been little improvement in ensuring that people get coordinated services from both health and social care when they need them. Recently, there have been many calls to set the NHS free from the Department of Health. Ironically, I believe that the more important question is how to set the Department of Health free from the NHS, so that it can take the lead across government and society on creating and implementing new policies for public health and social care. Ministers and the

Department would be far better placed to do this if they redefined their roles and distanced themselves to some extent from the NHS.

As well as unfinished business, there are many risks to face. Perhaps the most serious is that politicians and policymakers may succumb to the argument that the NHS cannot afford to be totally comprehensive and should not pretend that it can be. Therefore, it must restrict the range of services that it provides to a limited range of defined benefits and/or introduce greater co-payments for patients.

This argument is seemingly very simple and appears intuitively right, but its implications are dramatic. The NHS would become a safety net service of essential provision and minimum standards – and might slide towards becoming ‘a poor service for poor people’. However, there are powerful counter-arguments which broadly fall into two categories. The first suggests that a better way to tackle the costs of comprehensiveness would be to limit NHS treatments to what is known to work. If it does, the treatment should be available to all, regardless of the ability to pay. If it does not – or is very doubtful – patients may choose to follow their own instincts and judgement and purchase it for themselves. Drawing the dividing line consistently between what works and what does not will be exceedingly difficult. However, we already have

in the National Institute for Health and Clinical Excellence (NICE) a mechanism which performs part of this role. The second challenges the implicit assumption that higher quality necessarily means higher cost. There is plenty of evidence that beyond a certain point there is little correlation between cost and quality.

I suspect that this clash of arguments will form an important part of health policy debate in England over the next few years. The outcome will affect whether the NHS is able to maintain the principle of equity on which it was founded.

Paul Corrigan

Professor Paul Corrigan is Director of Strategy at the London Strategic Health Authority, and former Policy Adviser to Secretaries of State for Health Alan Milburn and John Reid. He was Policy Adviser to Prime Minister Tony Blair from 2006–07.

I am just a few months older than the NHS. I was brought up with detailed stories from my mum about how much luckier I was than my elder brother. For him, she had to save up half a crown on the mantelpiece every time he needed to go and see the doctor. For me, it was all free. And when, 50 odd years later, I became a special adviser working with the NHS, my mum said that she thought it was about time I gave something back to the NHS.

The most important achievement of the NHS has been to embed, as a part of the emotional and social relationships of British society, the greatest gift that the British people have ever given to themselves. That is, a health service that is paid for out of general taxation and based upon the principle of equal access for all, free at the point of need. The vast majority of the British people love these values, even though they are odds with the cash-nexus values of the capitalist society around it.

The reforms of the last 10 years have been implemented to develop a healthcare system that

maintains this principle. They have succeeded in further embedding that principle in British society, with every political party recognising that departure from those principles is electoral suicide. However, there is some way to go to ensure that they will provide the drive for further reform which will secure that future for another 30 years, let alone 60.

Healthcare systems around the world worry about their future because of two great threats. The first is an ageing population, and the second is the speed of the changes in medical technology. Our reforms must futureproof the NHS against these problems.

First, there is something odd about seeing this ageing population as a destructive issue, as it includes me. Yet every colour or travel supplement appeals to me, as a potentially active consumer who they see will be active well into my eighties. The picture painted of my life by the private sector is increasingly active. It is only the public sector which seems to assume that I am going to become a passive recipient of disease, and therefore a crippling burden, the moment I stop working.

When I am in my eighties it is likely that I will be suffering from a number of co-morbidities. There are likely to be some breathing problems, some arthritis, and I will be lucky if my cardiovascular system is still OK. A wise NHS will start talking

to me about how I can self-manage this when I am in my sixties. It will recognise that mine has been an activist generation, and that we will want to continue being active in developing our own health. A small resource spent on my becoming an expert patient now will save thousands of pounds in emergency admissions later. The NHS will save a lot of money and secure its own future by securing my co-production of my ageing health. Ageing populations ruin health services only if they develop passivity in old age.

Second, it is odd that it only seems to be health services that suffer from the problem that new technologies are remorselessly expected to increase costs. Nearly every other service or industry expects new technologies to save costs. So what is different with health services and new technologies? The answer can be seen in nearly all locations where health services interact with patients, and this is true across the world. Whether in primary or secondary care, most sites where patients are treated have a broad mix of new, adolescent, old and even venerable technologies. In fact, they represent a sort of archaeology of different layers of technologies. It is this archaeology that represents the cost of new technology for health services. We wrongly blame the cost on the newest technology itself, when in fact cost derives from organisational failure to help the newest technology drive out the old. Health staff, as with all other staff, develop habits

of carrying out their work which are challenged by new technologies and new ways of organising their services. Some make the transmission, but others feel that the way they have done things in the past stays best of all.

Health services that will thrive and survive will do so because they recognise that medical science and technology demand constant updating of patients' pathways. Successful pathways not only introduce the new, but are updated to reduce the old ways of doing things. This NHS will thrive and survive if commissioners incentivise healthcare that encourages the co-production of health, and decommissions old ways of doing things when new ones are being commissioned.

See you again when we are both 90.

David Colin-Thomé

Dr David Colin-Thomé, OBE, is National Director for Primary Care at the Department of Health. He was Senior Medical Officer at the Scottish Office from 1997–98, and Director of Primary Care at North-West (from 1994–96) and London Regional Offices (from 1998–2001).

The most significant and enduring achievement of the NHS must be its contribution to fairness and social justice. Paid for out of taxation and free at the time of delivery has been the abiding principle, which I feel remains sustainable. The NHS Plan of 2000 came to the well-evidenced conclusion that a tax-based system best meets the test of efficiency and equity. The Plan led to the large increases in monies for the NHS, but even prior to the extra investment, the World Health Organization ranking of the same year placed the UK as the 18th best overall health system despite being 26th for funding, but significantly it was the second best for its success in tackling health inequalities.

My personal but not unique view, based on my 40 years of experience in clinical practice as a general practitioner (GP), a local elected councillor and in national policy development, is that paradoxes in healthcare abound. These paradoxes are inevitable and difficult to tackle, and it is only the best managers and leaders that even recognise and seek to address them.

We have a health system that is founded on fairness and social justice, yet we often treat our patients as grateful supplicants rather than the experts in their healthcare needs that they are (for example, Tuckett described the optimal clinical consultation as a “meeting of experts”). We in the NHS crave independence and fewer national targets, yet until the advent of national service frameworks we did not systematically address the underperformance of the UK in cancer and heart disease outcomes. We spend large amounts of money on inappropriate and ineffective clinical services and yet when we address this, we face the ill-informed and populist accusation that the service is being rationed.

Of course, many of these issues are common to all health systems, in particular the contribution of health services to better health. We face increasing demands that the NHS should address almost single-handedly the social determinants of health when it is by partnership with others, in particular local government, that we can contribute best. The NHS can be only a junior partner in the struggle for health gain. Ultimately, successful strategies will be built on joint investment, targets and ventures between health and local authorities. For example, the clear evidence is that it is the educational attributes, especially of women, that lead to the best health outcomes and that most determinants of health lie outside healthcare, even

with the large increase in patients with long-term conditions.

Well-informed clinical leadership is fundamental if these paradoxes are to be resolved. Yet much of our leadership sometimes appears to focus on providing commentary and critiques rather than leadership. Of course, with power comes accountability, but as Professor Pieter Degeling opines, “transparent accountability leads to transparent autonomy”.

We know that a first-contact primary care system leads to a more effective and outcome-based health service, so more investment will be needed for more community-based services. Despite this, for many years we have focused unduly on hospital-based care. Specialist care is essential to a health service, but much of the care currently delivered in hospital can be delivered elsewhere, and sometimes not at all. But are current primary and community services up to the challenge? Julian Tudor Hart, an absolute doyen of general practice, said (and it surely applies beyond): “GPs are always laying claim to ground they do not wish to occupy.” General practice suffers from maldistribution, variations in performance and insufficient ambition. The future should see more devolved budgets for general practice and the extended team.

However, will this be acceptable in a service that is used to more centralised control? Practice-based budgets first introduced 17 years ago proffer much, but also signal another potential paradox: how do you regulate and hold to account budget-holders, yet in such a way that does not inhibit innovation? Such budgets have been shown already to incentivise more appropriate care, which can release resources to increase investment in services without needing much in the way of fresh NHS resources. Just as importantly, they offer incentives to focus ‘upstream’, so as to maximise the best use of resources. Quite literally, individual budgets for clients of Social Services have led to empowerment.

So, how much is devolution the answer to the NHS’s current problems? My observation is that when you devolve power to organisations, they become the new centralists. However, what is a valid HQ function at the centre of the NHS is an evolving concept, and must be subject to an ongoing deliberative process.

It is essential that we focus on encouraging and rewarding the excellent. Many will claim that such an approach simply will increase inequity in provision, but I do not want a forced equity at the cost of low ambition and, often, mediocrity. Let the best innovate and if it produces excellence,

we must spread it so we achieve an 'equity of excellence'. Tawney wrote that "the poor are much beloved by the Gods as they are given every opportunity to join them early". Are we doing sufficient for those who are underprivileged while maintaining responsive services for all? To me, this is not a paradox at all, but the hallmark of excellence.

Today's policy direction is for levers and incentives to predominate so as to encourage leadership. For many years, clinical leadership has been identified as essential, and yet in my 40 years in the NHS I cannot remember a year when low morale was not claimed! Primary care bears a particular responsibility, as to me it sits at the interface between the bioclinical world and that of the determinants of health. General practice, with its population responsibility, bears the most and is financed and technically trained well, but we will need different approaches to leadership if we are to realise the wider vision.

Would I be a GP if a young doctor again? Of course! To have a continuing responsibility for people rather than simply for a disease is particularly fulfilling. If there is any temptation to be smug or sanctimonious, there are always your patients to keep you straight. Early in my career I was opining on the merits of oral contraception, when I was told: "You don't have to b****y take them, do you."

Matthew Taylor

Matthew Taylor is Chief Executive of the Royal Society for the Encouragement of Arts. He was Chief Adviser on Political Strategy to the Prime Minister from 2003–06.

Discussion of public policy on health tends to revolve around two debates. The first is about the NHS as a system: how should it operate, what should be its priorities, where should power and accountability lie? The second is around the public: how can we encourage them to live healthier lives, how can we address health inequalities, how can we make people more active and responsible partners in their treatment? The hope that there may be a common set of answers to the questions posed by both debates does not diminish the tasks involved in defining and implementing this answer.

My own journey as a policy adviser involved a major learning process. When I started out in the 1980s (in a brief and unsuccessful academic career), I believed that what changed the world was policy. I knew little or nothing about systems and was uninterested in implementation. I emerged from 10 Downing Street in 2006 with a very different perspective. Policy may provide the recipe for successful change, but systems provide the ingredients (the materials on which the recipe must operate), implementation does the cooking and, however enticing the dish, without clear communication no one will come to dinner.

It is best to draw a veil over the record on health of Labour's first term. In the only major area in which it genuinely could be accused of complacency, Blair's ministers threw out the system reform baby with the Conservative bathwater. They foolishly assumed that the Tories had introduced competition, devolution and fundholding purely for ideological reasons. They failed to understand the organisational failings and policy frustrations which had formed the background to Kenneth Clarke's NHS Plan.

It was only in the second term that the classic New Labour reform model began to take shape. The goal was a system capable of continuous adaptation and improvement generated by the right combination of incentives and pressures from the centre (strategy, funding, capacity building), the side (diversity and contestability) and the bottom (choice and voice).

I still adhere to this model and have admiration for the fighting spirit of Alan Milburn, Tony Blair and, in particular, Patricia Hewitt, in trying to put such a system in place. That there has been so much pain and so many mistakes on the way is a kind of checklist of the barriers to major system reform. Poor communication and producer-interest politics stretching from Richmond House to the Royal College of Nursing solidified opposition when it needed to be dissipated. Political

expediency meant a loss of momentum at times when more was needed. Capacity failings at the centre, regions and localities meant weak strategic leadership and poor implementation. The sheer complexity of the system created – and still creates – perverse outcomes. Even the advisers and officials who knew their stuff were much better on the destination than they were at charting the journey. Also, there was something that big-thinking strategists all too often forget: while reform takes place, stuff still happens. Stuff such as MRSA, failing information technology systems, botched workforce reforms.

However, the reason we should continue with system reform is precisely because it is only in its ultimate (albeit inevitably incomplete) success that we will be able to focus our energies on the more substantively progressive, and vital, agenda of public empowerment.

In addition to current debates, for example about the future of primary and social care, there are three issues which, in my view, deserve growing attention. The first and most urgent is: how do we align incentives in the NHS so that prevention and self-care get more attention and resource in comparison to treatment? The second is: how we can join up objectives, funding and outcomes at the local level to maximise wellbeing, particularly in our poorer communities? Rather than an approach which simply targets one pathology

after another – obesity, mental health, alcohol and drug abuse – we need to understand how we build the efficacy and resilience of disadvantaged people and communities. Finally, the idea of health and social care as a co-production needs to move from the margins to the very centre of our vision of a progressive and sustainable system. After all, in the end, is not every patient an expert patient?



CHAPTER 3: "FOR THE GOOD OF THE PATIENT"

– MEDICAL LEADERS



Sir George Alberti

Professor Sir George Alberti is National Clinical Director for Emergency Access and a Senior Research Fellow at Imperial College, London. He was President of the Royal College of Physicians from 1997–2002.

It would be nice to say that I can recall the beginning of the NHS – but I cannot! I had already been active politically, having canvassed for the Liberal Party in the 1945 election (the start of a catalogue of support for lost causes), but contacts with our GP continued as before. My first professional contact was as a house officer, where I was informed repeatedly that I was lucky to be paid – I was graciously allowed one evening or night off per week and every fifth weekend. The learning experience was rich as there was just one senior registrar, one consultant and myself. Inevitably, this was potentially dangerous for patients, although one could do much less for them then compared with now, there was more time to do it, and cost was never a particular issue.

So what has happened since those gentler days? The most consistent theme has been that healthcare has continued to be provided free (more or less) at the point of delivery. This has to be the biggest achievement of all. The other major achievement has been the ‘professionalisation’ of the NHS over the past two decades, moving from a *laissez-faire*, comfortable environment

to a highly professional, accountable body, and with the focus moving rapidly to a cost-effective, efficient body with the emphasis on safe, high-quality effective care.

There is still a long way to go, however. My own involvement started with ‘efficiency’ savings, bed cuts and attempting to take Kenneth Clarke to court for abuse of public funds!

There have been three notable failures. The first was allowing independent contractor status to GPs at the inception of the NHS. This has perpetuated a great barrier between primary and secondary care when an integrated continuum of care is desirable. The second has been the continued underemphasis on prevention. Unless this is dealt with, the service will be less and less affordable. Obviously this is not a problem for the NHS alone; it is societal and requires multi-sectoral involvement, but the NHS could (and should) lead. Much of prevention should be directed at lifestyles and the argument is made that the state should not interfere – but we have done for smoking, we are doing so increasingly for alcohol-related problems, and more efforts are required with regard to food and exercise. The third is the continual reorganisation of the service before the previous reorganisation has been allowed to work. This detracts from the real work of the NHS and makes the workforce insecure.

Of course, there are other problems. One is the consistent failure of the NHS and the Government to communicate openly and honestly with the public about the safety and quality of their local services, leading to totally unrealistic expectations. Much can be provided locally, but not everything. This has led to a rash of 'Save Our Hospital' campaigns and has inhibited real advances. Another problem is the change in status of the professions over the years – particularly the medical profession – which has led to the dead hand of the professions and their leaders often inhibiting change rather than leading from the front. Big changes in medical training are needed to anticipate tomorrow's needs, with more emphasis on working across current boundaries and less rigid training programmes.

The first big perennial question is whether the NHS can survive as a tax-funded, largely free service. It must! The alternatives are extremely unappealing. Even a 90% effective service for all is preferable to a superb system which excludes significant numbers of people. This is where much bigger focus on prevention and behavioural change is essential. Of course, there are increasing pressures on the NHS. The population is ageing and better integrated services are needed for older people, with more attention to multiple co-morbidities and dementias. Also, we have not done well for the least advantaged people and more focus is needed on providing services and easier access for

deprived communities. Whether the private sector can help is questionable. Personally, I look on this as an unnecessary distraction, although it may have a role in provision of services in areas where the NHS cannot deal with everything on its own.

The second big question is: who should run the service, and should it be controlled centrally? On the one hand, a large amount of public money is involved, so it is unrealistic to expect no political or ministerial involvement. On the other hand, there should be no need for day-to-day interventions. There also needs to be clear central principles – perhaps enshrined in a constitution – and standards set for the whole service. This needs to be married clearly to considerable local decision-making as to priorities. Needs will differ between areas, and although this may lead to accusations of postcode lotteries, clear communications with the public and public involvement in decision-making in what will always be a cash-limited system may help.

What of the future? The current era really started with the NHS Plan in 2000 (one of my personal high points was involvement in production of the Plan). This set a direction which is still relevant. Much has been achieved, but a further incremental set of changes is now needed. There needs to be clear focus on the individual patient and everything should flow from that. Care should be planned around patient pathways,

not organisations, and integration of all levels of care is needed urgently. Professionals should be intimately involved so that the focus remains on care rather than organisational niceties. People should receive high-quality, safe treatment wherever they have contact with the NHS, and if this is not possible locally, then they should be prepared to travel. Major changes in hospitals are needed, with fewer acute hospitals attempting to do everything when palpable services are sub-optimal – and the training of professionals should reflect these needs rather than the ponderous reflections of august bodies. If logic, common sense, professional commitment and leadership and a focus on individual needs can drive the new NHS, then it will both improve and survive for a long time to come.

Dame Carol Black

Dame Carol M. Black, DBE, is Chairman of the Nuffield Trust, National Director for Health and Work and Chairman of the Academy of Medical Royal Colleges. She was President of the Royal College of Physicians from 2002–06.

In my view, the highest and enduring achievement of the NHS has been to maintain the civilised founding principle that healthcare (albeit with specified restrictions) should be free to all at the point of need. Referral to this principle has helped to keep alive earlier concepts of public service and the attitudes and behaviours that public service calls for, based on mutuality, fairness and unselfishness. I see no immediate reason why this principle should not endure, in the expectation that foreseeable advances in treatment and care will be made possible in three ways: through growing prosperity, a political will to maintain the principle, and a determination across the NHS to make the best and most ethical use of the resources made available to it.

The NHS has become more responsive to social and economic changes, high public expectations and new responsibilities and accountabilities. It has developed strengthened systems of financial accountability and quality assurance through regulation, inspection and clinical governance, the most significant of which, to patients and practitioners, should be local systems of clinical governance.

Among many notable achievements in healthcare over the past 60 years I single out one development that affirms the humanity of the NHS. It is the development of geriatric medicine and increased concern to give the best possible care to elderly people – in their millions and often with cumulative long-term problems – where careful attention can help to retain independence and alleviate conditions that together can seriously impair the quality of the later years of life. The model of geriatric care fostered in the NHS has been copied worldwide. It is an unsung achievement driven by a deep concern always to ensure the dignity and the best possible wellbeing of everyone, at every age.

The capability to treat illness, to cure, halt or alleviate the effects of illness and injury – to improve health outcomes – has grown, in some instances dramatically. So a disappointing feature of the NHS has been its comparative failure or tardiness, in important instances, to close the gap between the quality of healthcare that is possible with current knowledge and resources, and what is actually achieved. Improvements in quality and safety for each patient depend on shared motivation and coordinated efforts at every level, from national formulation of policy to local institutional and service function. Yet we know that despite high achievement by some, there are wide differences in performance both within the

Labour's plans for NHS 'would cause turmoil'

DOES Labour have a workable programme to save the National

By Nicholas Timmins Political Correspondent

Watchdogs fear NHS closures

Private operations bought by health service 'cost double'

National Audit Office: NHS private sector

NHS 'facing a stark choice'

NICHOLAS TIMMINS Public Policy Editor

PUBLIC HEALTH

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Whitchall-wide action to reduce health inequalities

Tories set for U-turn on private health care

Government is poised to scrap tax relief on private health

Waldegrave signals that Thatcher

on need to wipe out debts before health service 'm

cuts 4,500 beds to save

by The Independent, to

NHS and in comparison with countries at similar stages of health service development.

A major underlying weakness – one that is now widely acknowledged and is being addressed – has to do with the need to engage clinicians more fully in management and leadership roles within the NHS, and to bridge the acknowledged gaps in thinking and behaviour between clinicians and management and with government. Coherence, integration and transformation of services do not come through *diktat*, neither do they emerge out of organisational constructs imposed from above. Rather, they emerge and sprout from clinical practice, from its values and culture – the professionalism that is the foundation of good practice.

Speaking of the Review that signals the 60th year of the NHS, prime minister Gordon Brown said:

*Lasting change can only come from clinicians and staff. We need to do much more to empower staff, to give them the time with patients that they need to improve patient care, to put them in the lead in developing ideas on improving patient care, and to respect their professionalism.*¹

A welcome statement indeed. At the level of local service delivery, closer alignment between professional groups in their thinking

and behaviour has become essential now that multidisciplinary working, at team and network levels, is the accepted (indeed necessary) mode of service delivery.

These matters, not confined to the NHS but also raised in other countries, have generated a searching and, I am confident, extremely promising discussion of the changing concepts of professionalism – initially of medical professionalism and the roles of doctors, and now of other professions and disciplines who together are responsible for delivering care – in a health service for a society that is so different from that of 60 years ago.

Such considerations highlight the central importance of education and lifelong training and development, fundamental activities on which improved quality and performance – and hence the excellence to which the NHS should aspire and so retain the trust of patients and public – so crucially depend.

The now-familiar challenges to the NHS have opened up new discussions among professional and other bodies with interests in health matters and the public. There is now a rich and open dialogue, matched by practical actions in ways that were uncommon even 10 years ago. So I see 60 years as marking a significant stage for review, providing not just an opportunity but the

1. Department of Health. *Our NHS Our Future: NHS Next Stage Review – Interim Report*. London: Department of Health, 2007.

stimulus for reinvigoration, if we are to maintain and enhance the founding values of the NHS and the professionalism of those who serve in it, and provide the high-quality universal service that patients and the public are right to expect.

Sir Graeme Catto

Sir Graeme Catto is President of the General Medical Council and Professor of Medicine at the University of Aberdeen.

Personally, I blame the Democrats. I spent the summer of 1968 courtesy of Andrew Carnegie as a final-year medical student at Northwestern University and Passavant Hospital, Chicago, and attended outpatient clinics at the legendary Cook County Hospital. I fell in love with the people, the city and the country. The standard of medicine was impressive and the attending physicians practised evidence-based medicine long before it became fashionable. During the Democratic Convention we received casualties from the confrontations between the National Guard and the hippies in Grant and Lincoln Parks; I stayed in the hospital where beds, fortunately not needed, were kept for the president and vice-president. It was exhilarating and I knew I would be back.

Seven years later I had a Harkness Fellowship from The Commonwealth Fund of New York to study nephrology and immunology at Harvard University and the Peter Bent Hospital, in Boston, MA. The hospital, linked to Harvard Medical School and built as a fever hospital after the First World War, was physically decrepit, but as the plaque in the entrance stated, "Within these crumbling walls, medicine of the highest standard is practised." And it was. We lived in Brookline, the children went to excellent local schools and my wife

studied at the Kennedy School of Government in Cambridge. My clinical and research work went well. Life was good.

Two years later, we decided to leave the security of renal medicine in the USA and return to a UK then in the grip of inflation and the 'Winter of Discontent'. While we were settled and happy, we were uncomfortable with the great inequalities in American society, particularly the inequalities in healthcare. Treatment for renal failure was funded federally, so the patient's income was irrelevant in my specialty – but that was the exception. The hospital provided excellent care, but only for those who could afford it. The NHS offered the prospect of a fairer system.

So how has it been, and what do I hope for the future? Well, it has been OK for the most part. We still have a health system that is free at the point of need and delivering for the most part good quality care, and it still has considerable public support. Personally, I am relaxed about the method of funding; the current approach is probably fairest – if, and only if, management is capable of delivering a modern and efficient service. Any alternative methodology based on reimbursing costs has to balance the additional financial overheads against the desired increases in efficiency. In any event, political supervision is inevitable, given the sums of public money involved. Both central direction and local

accountability are needed; swings from one to the other are unhelpful. The NHS should learn from the private sector and elsewhere – although some former models of good practice, such as British Airways and Marks & Spencer, have fallen on hard times. Even the competition–collaboration debate has a somewhat dated feel to it, perhaps because the health service is developing in different ways in the four countries of the UK.

Is the future to be just more of the same? I do hope not. Over the last few months the General Medical Council (GMC), together with The King’s Fund and the Royal College of Physicians, has held a series of roadshows with medical schools both ancient and modern. The students emphasised three issues of importance to them. The first was their professionalism: that set of values, behaviours and relationships which underpin the trust that the public has in doctors, nurses and the other healthcare professions. They did not believe that their future contractual responsibilities would replace their professional commitment, but rather, they should build on it. Recent attempts to shape the health service using centrally agreed contracts have not resulted yet in improved patient care, and there may be real gain to the patients and to the professions if revalidation (based on the GMC guidance *Good Medical Practice* for doctors)¹ is introduced without further delay. A combination of contractual and professional undertakings may prove to be a powerful way

of delivering effective and efficient clinical care. Merging the Postgraduate Medical Education and Training Board with a reformed GMC, still independent of the Department of Health and accountable to parliament, is a step in that direction; strengthening responsibilities for medical education and training, and ensuring effective workforce planning within the Department of Health would be another.

The second was the self-confidence of the profession. The students thought that often, the views of doctors were ignored, with the result that many of the younger doctors now undertake their clinical duties but choose not to become involved in wider matters affecting the health service locally or nationally. The students perceived this apparent apathy as potentially more dangerous for the future of the health service than outright opposition.

The third was leadership. Beginning at the national level, the students did not envisage a single messianic leader able to resolve apparently intractable issues at a stroke of a mighty pen; medicine is too diverse for that simplistic approach. However, they did believe passionately that leaders in the different branches of medicine should cooperate effectively to resolve problems before they reach the crisis stage. The lessons from Modernising Medical Careers (MMC) and the Medical Training and Application Scheme (MTAS)

1. General Medical Council. *Good Medical Practice*. London: General Medical Council, 2006.

are clear to all. More than that, they believed that leaders must focus not only on the immediate issues facing their individual organisations, but must cooperate effectively to address the wider expectations of patients and the public. The students expected that we shall all work together to identify and eliminate poor practice and the squalid surroundings that put patients at risk, always seeking to provide quality care.

These principles are equally relevant to local situations and our individual practice. We must all have leadership skills. Organising a care plan for a patient requires leadership. Working in teams, it is inevitable that from time to time we shall be required to lead. The necessary skills must be acquired as part of undergraduate education and postgraduate training, recognising that supporting another leader is an essential component. A minority of doctors will wish to pursue leadership roles at local, national and international levels; for these individuals, the essential skills will be acquired as part of continuous personal development.

It is increasingly clear that the UK has not utilised yet the leadership ability of our doctors to deliver improvements in patient care as effectively as some other countries (e.g. Denmark, the USA). That deficiency must now be rectified if the NHS is to meet the needs of patients and society in the years to come. Disengagement of doctors,

for whatever reason, disadvantages the NHS. The future NHS will need the leadership that can come only from confident and caring doctors, nurses and other healthcare professionals.

Sir Cyril Chantler

Sir Cyril Chantler is Chairman of the Board of the Great Ormond Street Hospital for Children NHS Trust and of The King's Fund, London. He served as a member of the NHS Policy Board from 1989–96.

*I am quite convinced that the National Insurance Act and this Bill will prove by far the greatest social reforms which have been passed by Parliament and will bring health happiness and security to millions.*¹

So said the Archbishop of York, Cyril Garbett, in 1946 during the debate on the National Health Service Bill. This, in my view, is the wonderful achievement of the NHS. I sometimes think that, had Thomas Jefferson written the Declaration of Independence 200 years later, he would have included healthcare along with life, liberty and the pursuit of happiness as an inalienable right for the citizen. However, it can be argued that the secret of its success is also the cause of its failures. Enoch Powell, reflecting on his years as Minister of Health, wrote in 1966:

*The universal exchequer financing of the service endows everyone providing as well as using it with a vested interest in denigrating it, so it presents what must be the unique spectacle of an undertaking that is run down by everyone engaged in it.*²

The difficulties of the NHS are faced by all publicly-funded healthcare systems. All such systems are rationed (or more accurately, restricted) in terms of what is provided, when it is provided or to whom it is offered. Thankfully we are restricted in terms of what and when, not to whom. Powell argued that waiting lists were an inevitable consequence of a tax-funded system but other countries have not found this to be the case, and indeed the present government has been successful in reducing ours. Some would argue that this is because of increased spending; others point to the influence of targets and a degree of competition, at least in the provision of planned care.³

I qualified in 1963, became a consultant in 1972 and began to argue vigorously for resources to treat children with kidney failure. In 1975 my colleagues and I set out a plan for a network of centres throughout the UK, each with the necessary facilities and services.⁴ The idea was based on a similar plan in the USA which had foundered because central planning was not acceptable. It reminded me of the remark, attributed to John Preston, that "the nicest thing about not planning is that failure comes as a complete surprise and is not preceded by a period of worry and depression". While our plan was accepted, it was not implemented. Some time in the early 1980s Mrs Thatcher was interviewed on television and asked about the failure of the

1. Garbett C.F. Hansard, Vol. 143, Col. 35, 1946.

2. Quoted in Chantler C. Worth a Second Look. A New National Health Service? *Journal of Health Services Research and Policy* 2002; 7: 118–20.

3. Dixon J. Darzi Review of Quality of Care in the NHS. *British Medical Journal* 2008; 336: 844–5.

4. Chantler C., White R.H.R., Houston I. *Future Care for Children with Renal Failure*. British Association for Paediatric Nephrology, 1975.

Government to provide bone marrow transplant facilities in some areas, an example of what later became known as 'postcode rationing'. She responded that the Government planned to introduce supra-regional funding for some clinical services. I was told later that this was news to the Department of Health, but they had our plan and out of the drawer it came. We could soon claim, and can still do so, that services for children with renal failure in the UK are as good as anywhere in the world.

However, this was but one example of the growing gap between what technology could provide and what was deemed affordable.⁵ This problem remains in spite of massive increases in funding for the NHS. Personally, I believe that the introduction of the National Institute for Health and Clinical Excellence (NICE) has provided a more rational basis for determining resource allocation, and that there needs to be a hierarchy for deciding what clinical treatments should be provided by the NHS that takes account of national priorities, local priorities and the particular circumstances of the individual patient.⁶

The problem that the NHS faces on its 60th birthday is that the pattern of illness, the needs of patients and the attitudes of society have changed. Those of us who were involved in the recent review of the NHS in London led by Professor Darzi,⁷ were aware that nearly 80% of expenditure now goes on the management of chronic illness, that Londoners think that access to the service is unsatisfactory, and that unless we can find ways to become more healthy or at least less unhealthy, the service may not be affordable.⁸ All these factors are worse for the disadvantaged: the inverse care law is still at work! The quality of clinical services,⁹ productivity,¹⁰ the integration of the services necessary to manage chronic illness^{11 12} and the promotion of health are all matters of concern, but the NHS provides few incentives to deal with these issues. I would argue that the reason lies within Powell's bleak analysis of 1966. The top-down power structure means that the NHS is accountable to politicians or their agents, in part to professional organisations but hardly to patients as individuals.

Obviously there are many options for reform: we could even copy some of the successful

5. Ham C., Robinson R., Benzeval M. *Health Check: Health Care Reforms in an International Context*. London: The King's Fund, 1990.
6. Chantler C. Health-Care Technology Assessment: A Clinical Perspective. *International Journal of Technology Assessment in Healthcare* 2004; 20(1): 87–91.
7. NHS London. *Healthcare for London: A Framework for Action. A Report Chaired by Professor Sir Ara Darzi*. London: NHS London, 2007.

8. Wanless D., Appleby J., Harrison A., Patel D. *Our Future Health Secured? A Review of NHS Funding and Performance*. London: The King's Fund, 2007.
9. Institute of Medicine. *Crossing the Quality Chasm*. Washington, DC: National Academic Press, 2001.
10. Wanless et al., *Our Future Health Secured*.
11. Chantler C. The Second Greatest Benefit to Mankind? Harveian Oration. *Lancet* 2002; 360: 1870–7.
12. Ham C. Competition and Integration in the English National Health Service. *British Medical Journal* 2008; 336: 805–7.

systems available in other countries. Personally, I am in favour of a tax-funded system without co-payments, in spite of Powell’s criticism. I used to think that competition was unnecessary, that transparency of outcomes with some contestability would suffice to increase quality and efficiency.¹³ Now I do not think we can make progress without clear accountability to the patient (i.e. the patient, not just patients represented by focus groups, elected councillors or hospital governors – desirable though they may or may not be). Choices for planned interventions appear popular and have increased productivity, at least as judged by declining waiting lists and shorter waiting times.

The foundation of the service is, and should remain, good general practice, but in my view more competition is required to improve standards and drive out poor practice. More choice for patients between GPs is necessary and it must be made easier to change practices. Chronic disease management requires integrated care, cooperation between GPs and specialists and between different professionals in hospital and in the community. There are many ways of seeking to provide this but it would be possible, as envisaged in the 2006 White Paper,¹⁴ to pilot integrated care

organisations commissioned by primary care trusts to deliver the totality of care to a population of around 100,000 people.^{15 16 17}

The funding would come from the total capitation for each patient, perhaps adjusted according to a person-based risk allocation formula. In other words, the citizen would be given the tax back to spend in a regulated system with some choice, albeit limited. The value in terms of outcomes and costs should be evaluated carefully. Such a system could serve at last to balance the interests of the patient with that of politicians and professionals. I acknowledge that both these groups have legitimate roles in the management of the NHS, but accountability to the patient is vital if standards and efficiency are to be improved.

13. Chantler, *The Second Greatest Benefit to Mankind?*

14. Department of Health. *Our Health, Our Care, Our Say: A New Direction for Community Services*. London: Department of Health, 2006.

15. Ham, *Competition and Integration in the English National Health Service*.

16. Donaldson C., Ruta D. Should the NHS Follow the American Way? *British Medical Journal* 2005; 331: 1328–30.

17. Dixon J., Chantler C., Billings J. Competition on Outcomes and Physician Leadership Are Not Enough to Reform Healthcare. *Journal of the American Medical Association* 2007; 298: 1445–7.

Sir Liam Donaldson

Professor Sir Liam Donaldson is Chief Medical Officer for England.

When I was a medical student, a consultant teaching us in outpatients asked a patient to undo one button of his shirt and pull it open. As he slipped his stethoscope through the aperture and onto the patient's chest, he turned to us and remarked, "This, gentlemen, is the national health triangle."

In the late 1960s, two decades after the foundation of the NHS, patients were expected to show respect and gratitude, while senior doctors were free to exhibit bombastic and condescending behaviour. Some did. Too often, a complaint was taken as an affront, while pitching too many questions at a doctor was liable to lead to someone being labelled as a 'difficult patient'.

Much has been said about the death of deference in the second half of the 20th century, but its demise has been slower in the NHS than in British society in general. The seminal moments in finally challenging the imbalance of power between doctor and patient are to be found in a series of medical scandals in which patients were harmed or treated disrespectfully. These ranged from individual 'rogue doctor' cases, through whole-service failures (e.g. the misdiagnoses in the Birmingham bone tumour service), to the wishes of patients being taken for granted (e.g. the

retention of dead children's organs at Alder Hey Hospital without parental consent).

Matters came to a head in the Bristol Children's Heart Surgery Service. Mortality rates were high, concerns were expressed, yet the surgeons carried on operating. The subsequent inquiry spoke of a 'club culture' in the service. Bristol mothers picketed the General Medical Council (GMC) headquarters with cardboard coffins. Later, the general practitioner Harold Shipman was convicted of murdering 13 of his patients and judged to have killed 250. Some said that no one could predict or prevent the rare occurrence of a health professional with malign and devious intent. Yet there were echoes in an earlier case in which a hospital nurse, Beverley Allitt, had been convicted of systematically murdering her patients.

All these substantial events – the small-scale and the larger – pointed to an adverse culture prevalent in some parts of the NHS. Poor practice was tolerated or concealed. Systems of problem detection were inadequate. Most importantly, in such cases, the interests of the patients were subordinated to other considerations such as professional solidarity, fear of media exposure and avoidance of litigation.

These examples relate to matters of life, death, dignity, respect and safety. Another challenge to the NHS arose more in the area of consumerism.

Why should a patient requiring three sets of tests have had to make three separate visits to the hospital rather than having them performed in one short visit? Why did patients have so little information about their condition or clinical circumstances? Most importantly, why did patients have to wait so long?

Only at the beginning of the 21st century was patient-centred care debated extensively and authentically. Major reforms shifted the balance of power and improved the experience of patients. Clearer standards were set through which practitioners and NHS organisations can be held to account more explicitly. New procedures were put in place so that poor clinical performance can be recognised early and interventions made to protect patients. Promotion of a culture of clinical governance has brought with it an intolerance of bad practice and a spirit of quality improvement. Major reforms to the GMC and the process of medical regulation are introducing an explicit approach to assessing clinical performance that will underpin the traditional trust in the quality of medical practice.

Learning from airlines and other high-risk industries, a programme of patient safety has been introduced to strengthen systems and reduce the impact of error when it inevitably occurs. A national scheme to report all adverse events, analyse their causes and learn how to reduce risk

has the potential to make patients safer than at any time in the history of the NHS.

Alongside these reforms, policies have been formulated to enhance further the patient's experience: for example, more choice as well as feedback from, and publication of, patient surveys, together with periodic inspection of facilities and fields of care. Moreover, attention has been directed to simplifying processes of care, in order to make them more patient-friendly, led by the Modernisation Agency and its successor body, the NHS Institute for Innovation and Improvement.

The NHS today is a much more patient-focused service than it was at its foundation. Yet formidable challenges remain to making 21st-century healthcare a genuine partnership between those who deliver care and those who receive it. A modern health service should be equally intolerant of a condescending remark as it is of a poorly-fitted hip joint replacement. Developing this patient-centredness must be addressed at the systems level (e.g. through funding flows and incentives) right through to the frontline of care, where culture, procedures and leadership must all be aligned to excellence.

James Johnson

Mr James Johnson is a consultant surgeon at Halton General Hospital. He was Chairman of Council at the British Medical Association from 2003–07.

I suppose the biggest surprise in a very long time in medical politics was to hear Tony Blair casually announce one Sunday morning on television that he would bring spending on the NHS up to European levels over a period of five years. Did he mean it? Would he go through with it? It seemed like the end of a financial nightmare: the dreadful three or four-year cycle when the NHS would get increasingly into debt with consequent accompanying scandals, until a reluctant chancellor grudgingly put another £3 billion into the NHS budget and the cycle began again. The medical profession always had said that the only thing wrong with the NHS was that it was not properly funded. Just pay up and all would be well. At last, someone had listened.

In retrospect we might have realised that funding was not the whole problem. Just look at the USA: lavishly (and wastefully) funded, but giving very variable care and with outcomes that are worse than the UK. Or look at Scotland: historically better funded and much better staffed from the start of the NHS, but with health outcomes that England would not wish to emulate. Of course the NHS needed reform – to be more customer-focused and less paternalistic. It needed a stimulus

to make waiting lists and lack of choice go away. The reforms should have been worked out and the extra money used to implement them, but such was the haste to spend the money that we only seriously got round to thinking of the detail of reform when it had all been spent. The result was certainly improvement for patients, but at disproportionate expense. There were hugely increased wage bills, but no commensurate increase in productivity.

Looking to the future, money will continue to dominate the scene. All over the world, increasingly expensive but effective treatments are being developed, week-by-week. Sometimes savings go alongside – an expensive bit of kit for keyhole surgery might be offset by a shorter stay in hospital – but the trend is inevitable and inexorable, and effective healthcare will become more and more difficult to afford. All this makes the key issue for any government anywhere to squeeze the maximum possible health gain for every pound, dollar or euro spent.

Certainly, we have not got there yet, and the messages coming out of the Department of Health are at best mixed and sometimes contradictory. At least the system of patients choosing where to access care and the money following the patient should keep taxpayers happy. However, will they choose interventions that squeeze the last drop of care out of every pound spent? Will care be

better provided in community settings? If so, why do we persist with a financial system which makes hospitals hang on to everything they can possibly do within their walls? Does the Department want to delegate decision-making to local level as it says, or does it wish to hang on grimly to the old Soviet-style command-and-control economy, as its every action suggests?

Another certainty for the future is the dependency ratio: the proportion of people who earn money, pay taxes and do the caring to those who are supported by the state. At the beginning of the health service, the ratio was about 5:1. You retired at 65, died at 67 and the cost to the state of keeping you for those two years was manageable. However, some estimate that by the middle of this century the ratio may be more like 2:1: two people to generate the wealth and provide the care for every one who is dependent. Clearly, the issues here go way beyond health. Working lives and pensions will have to adapt to the new realities of longevity and degenerative illness, however unpopular this may be with workers. The burden on health and long-term care will swamp completely our ability to cope unless some very radical (and urgent) thinking takes place about how to deal with the demographics.

Possibly the greatest problems can be found in commissioning. The concept of providing services based on detailed assessment of local

needs is difficult to fault and certainly fits well with the concept of ‘value for money’. However, few primary care trusts have the necessary expertise in healthcare design, data analysis, contracting and procurement, not least to mention performance management. Is there much point in commissioning if the patient makes the choice rather than the primary care trust or GP practice? In truth the jury is still out on the concept of buying and selling healthcare, and while a little competition has certainly brought greater efficiency to acute surgical procedures, it is difficult to find any benefits in terms of chronic disease or preventive health. Recently, Chris Ham has argued the case for integrated systems, with primary care reaching into secondary care. Lord Darzi wants to see specialists integrated more into community settings. Admirable as these ideas may be, there is little incentive at present for employing organisations to change the way things are because their financial stability depends on more of the same. What hospital is going to cut its own throat by encouraging its key earners (consultants) to go to work for someone else?

So, the crystal ball remains as murky as ever. We have to be efficient, but we have not begun to decide how. To me, provided that a finite range of core standards are met, the argument to let localism flourish seems incontrovertible. Regulation of institutions and professionals should be light-touch, integrated and concerned with

meeting core standards. Beyond that, it is matter for individual practices and organisation to provide evidence of excellence to attract business. All this will produce an environment where innovation and imagination will produce results and flourish. Confused *diktats* from the centre have not served us well in the past, and are unlikely to do so in the future.

Bernard Ribeiro

Mr Bernard Ribeiro, CBE, was a consultant general surgeon at Basildon University Hospital. He is President of the Royal College of Surgeons.

The 60th anniversary of the NHS is providing healthcare professionals and commentators, politicians and the public with a timely opportunity to recognise its achievements, acknowledge its shortcomings and reflect on the challenges that lie ahead. It is appropriate also that this remarkable institution should be reviewed and its future direction debated at a time when there are, as we call them today, drivers for change on a scale and complexity previously unknown. These factors include:

- the continuing process of reform within the health service and across the care sector as a whole
- increasing specialisation across medicine and healthcare generally
- the case for reconfiguration of services at various levels
- the impact of domestic and European legislation, in particular the Working Time Directive
- the changing dynamics of the medical and nursing workforce
- the relentless advance of technology
- the changing structure of the population, specifically ageing

- trends in public health and the emergence of new priority conditions such as obesity and alcohol-related disease
- the increasing expectations of a better-informed and more demanding public
- intensifying pressures within the national economy, specifically on public expenditure.

Many overriding issues are emerging for the NHS and no doubt these will undergo continuing analysis. I will focus briefly on two: one a personal conviction, the other a more widely-recognised professional priority.

The first issue relates to the funding of the NHS. In the 11 years since the election of the New Labour government, many billions of pounds have been added to the NHS budget year-on-year and the annual figure is now approaching £110 billion. The Government's stated aim was to bring national expenditure on healthcare up to the average level of our European partners. Broadly, this has been achieved, but there remain areas of healthcare provision that do not match the level or quality of services provided in other comparable countries, and undoubtedly there will be other areas where these drivers for change will bring further pressure on resources. For example, in the years to come, the ageing of our population alone will result in enormous additional demand for care for those suffering from dementia, and add to this

the impact of treating the increased incidence of degenerative disease.

In these circumstances, I cannot see how the long-term funding of the NHS through general taxation will be sustainable. There are a range of examples from our European partners of alternative systems for funding healthcare. In particular, we would do well to examine the arrangements in Switzerland and the Netherlands, where equitable social health insurance schemes have ensured continuing quality care despite rising costs and without requiring employer contributions, a sticking point in other systems. No political party in this country has shown any interest in discussing, far less moving towards, an alternative funding model. On present trends, their only other option, no less politically unpalatable, would seem to be an intensification of the debate about rationing.

Regardless of funding arrangements, a second issue will be central to the future provision and development of our health services. After a decade or more of a relentless and often misguided target culture in the NHS which has distorted and marginalised the clinical basis for many aspects of patient care, politicians, the profession and the public now seem agreed on the importance of quality and its measurement. Effective measures of quality of care will be essential in the NHS of the future to enable patient choice, ensure effective commissioning and promote best practice. Surgery

will be at the frontier of this initiative, developing outcome measures across its specialties in the wake of the pioneering steps of cardiothoracic surgery. However, we will move from the ultimate measure, mortality, which has underpinned that specialty's work, to a range of clinical and patient-reported indicators more appropriate to the great majority of surgical interventions. Progress will be gradual, based initially on a few index procedures and team or unit rather than individual results, but the process will start immediately.

More generally, priorities in health will need to be identified. The provision of emergency services must become the number one priority. All patients must feel safe in the knowledge that, if seriously ill or requiring an emergency admission, they will be treated in the most appropriate hospital for their needs.

The development of a national trauma service will ensure that trauma centres are equipped to provide all the specialist services on one site. This will drive the reconfiguration of emergency services. The further constraints of the European Working Time Directive, to take effect in 2009, will make it increasingly difficult to provide an emergency surgical presence in every Accident & Emergency department in the UK. In future, quality outcome measures will dictate which hospitals will provide emergency services in surgery. Ministers will have to decide how other

priorities in healthcare can be afforded and which vulnerable members of the community must be protected.

Reflecting on my career in the NHS, what have been the highs and the lows? The introduction of therapeutic laparoscopic surgery to the UK in 1989 changed the whole practice of general surgery. During the previous decade I had used laparoscopy as a diagnostic tool, little appreciating its potential. I performed my first laparoscopic cholecystectomy in 1990 and was amazed at the speed of recovery of my patients. For once it was the patients who were telling the surgeon when they were ready to go home. The lengthy stay in hospital associated with open surgery gave way to an overnight stay or a day-case. The benefits to patients have been enormous, and the new skills learned by surgeons have led to the development of more procedures and the arrival of robotic surgery.

2007 will be remembered forever for the Modernising Medical Careers (MMC) and Medical Training and Application Scheme (MTAS) debacle. The attempt to change medical training at a stroke failed spectacularly, causing misery and despair to thousands of young doctors, many of whom failed to secure the training post of their choice. Despite efforts to improve the selection process, fundamental issues remain. The future for the lost tribe of senior house officers in surgery remains bleak, and solutions are urgently required.

CHAPTER 4: OUTSIDE VIEWS



David Costain

Dr David Costain is Medical Director of AXA PPP Healthcare.

In 1974, when it was 25 years old, after unprecedented planning and consultation and with no apparent opposition, the NHS was reorganised. At the time, this was described as the most fundamental change to health services since the NHS was established. To those of us working as clinicians at patient level in the service, the change was almost invisible, being limited to the wholesale change of notices and signposts throughout the hospital (I doubt if any of the patients noticed even that). Commenting on this at the time brought the response that those of us working in hospitals could not be expected to understand how, by integrating local authority health services with the NHS, these changes would transform community care. (This could not have worked either, as I was recently told by a senior political adviser, that the impending introduction of a common regulator was the sure way to ensure seamless working of these services. *Plus ça change.*) A mere two years after this, a Royal Commission was appointed to look at the NHS, presumably because it was believed that the expected improvements had not materialised.

Did we learn anything from all this? There have been a further 20 reorganisations of various types in the years since, not quite one a year, and still

the urge to rearrange the deckchairs persists. Sir Muir Gray reminded me recently that, in fact, some people had become wiser; NHS chief executives have been known to take space in the local press to reassure the public that they will not notice any change to the service resulting from the latest reorganisations. The corollary of this observation is that it is very difficult to make material changes to the way in which healthcare is delivered by issuing edicts from the centre. This is almost not worth saying as it is largely universally agreed – except where it matters.

Perhaps because of this dominance of the centre, the will to do anything new locally can be weak. When I grew up and became a hospital manager, in a place I had never previously set foot, I was amazed at how high a proportion of the staff had never worked anywhere else, and of those that had, it had not been for very long. If they were senior enough they would go to an annual conference of their professional interest, but this still meant that they never met anyone from outside their own sphere, outside their own hospital. Thinking they were deprived in some way, I tried to use the trust funds to help them broaden their experience. I could not persuade a single person to take the opportunity to do so. I could never decide whether this was out of fear or arrogance. This resistance to change was a massive failure in the organisation.

Inability to question the appropriateness of types of care and behaviour has a direct impact on patients. For example, recently my father was injured in an accident. Getting from casualty to the ward involved two changes of bed. Having seen how painful the first one was, I objected to yet another, only to be told that although the beds looked identical, they belonged to different wards and were not interchangeable. I have no doubt that this state of affairs seemed to be a good solution to the game of 'Pass the Parcel' with wonky beds, but it demonstrated to me that the service was still run for the benefit of staff, not patients. This is not only objectionable but also unsustainable, in even a mildly consumerist society. The tradition of people accepting inconvenience from the NHS that they would not from any other service is showing clear signs of changing. A constitution for the NHS can only accelerate this.

The pressures facing the health services in all countries are well known and irresistible. The desire to offer everyone equal access is politically universal. The need for the majority of the funding to come from the state, either through taxation or tax allowances, is unarguable. However, to fund it all from the state is, ultimately, unaffordable. The rate of medical cost inflation outstrips the growth rate in all developed countries and is expected to consume all the growth sometime this century,

perhaps as early as 2030 in the USA. The NHS in its current form cannot cope with this.

We seem incapable of planning for meaningful change. Secretaries of state will not let go of the NHS, but neither will they take the risk of major change. There is no 'upside' in it for them politically. So such change will come about only when it is inevitable: that is, when it is stretched to breaking point. It will have to get worse before it gets better.

Karen Davis

Karen Davis is President of The Commonwealth Fund.

The NHS has made significant progress over the last decade and continues to deliver better value for the resources invested in healthcare than health systems in many other countries. Most notably, the US surveys of the public, sicker adults and physicians since 1998 sponsored by The Commonwealth Fund have shown systematic improvement in the UK on quality of care.¹ The UK now ranks first among six nations on a health system performance scorecard which includes

dimensions related to health outcomes, access, quality, efficiency and equity.²

Unlike the USA, where 47 million Americans live without insurance and millions more skip care and go into medical debt because they are under-insured, the UK offers its residents publicly-funded, comprehensive healthcare coverage through the NHS. The NHS also serves as a large integrated delivery system, lending itself better to innovations and efficiency than the fragmented USA system, which many argue is not a 'system' at all. The UK's primary care infrastructure and orientation, where general practitioners serve as a first point of service for patients, also distinguishes it from the USA, where primary care is suffering due to misaligned payment incentives in its fee-for-service system. The UK's primary care focus offers opportunities not only for better preventative and chronic disease care but also lower-cost care.

Thanks to many of these factors (as shown in Figure 1), the UK ranks first on an average of more than 65 indicators of health system performance.

Figure 1. Health system ranking: six nations

	AUSTRALIA	CANADA	GERMANY	NEW ZEALAND	UNITED KINGDOM	UNITED STATES
OVERALL RANKING (2007)	3.5	5	2	3.5	1	6
Quality care	4	6	2.5	2.5	1	5
Effective care	5	6	3	4	2	1
Safe care	4	5	1	3	2	6
Coordinated care	3	6	4	2	1	5
Patient-centered care	3	6	2	1	4	5
Access	3	5	1	2	4	6
Efficiency	4	5	3	2	1	6
Equity	2	5	4	3	1	6
Long, healthy, and productive lives	1	3	2	4.5	4.5	6
Health expenditures per capita, 2004	\$2,876*	\$3,165	\$3,005*	\$2,083	\$2,546	\$6,102

* 2003 data.

Source: Davis K., Schoen C., Schoenbaum S.C., Doty M.M., Holmgren A.L., Kriss, J.L., Shea, K.K. (2007) *Mirror, Mirror on the Wall. An International Update on the Comparative Performance of American Health Care* New York: The Commonwealth Fund.

1. Schoen C., Osborn R., Doty M.M., Bishop M., Peugh J., Murukutla, M. Toward Higher-Performance Health Systems: Adults' Healthcare Experiences in Seven Countries. *Health Affairs* 2007; 26(6): w717-34.

2. Davis K., Schoen C., Schoenbaum S.C., Doty M.M., Holmgren A.L., Kriss J.L., Shea K.K. *Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Healthcare*. New York: The Commonwealth Fund, 2007.

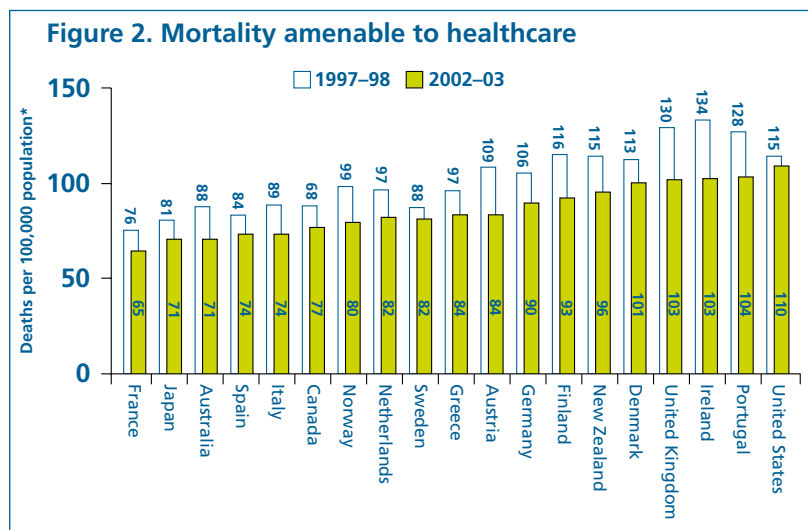
It fares especially well on the domains of quality, efficiency and equity, but continues to lag behind other countries on access to care and health outcomes. Within the quality domain, the UK does particularly well in ensuring that patients receive clinically-effective services, and care is more efficient than in the other five countries. However, UK performance on patient-centred care leaves room for improvement in comparison to Australia, Germany and New Zealand. The country also performs well on patient safety, although there are still measures such as hospital-acquired infections

where the UK has relatively poor performance. The UK stands out for its treatment of patients with chronic conditions; patients with diabetes are more likely to receive appropriate care in the UK than in other countries.

While the UK has fallen short on health outcomes overall, it has made impressive performance improvements in mortality amenable to medical care, falling from 130 deaths per 100,000 in 1997–98 to 103 deaths per 100,000 in 2002–03, moving up from 18th to 15th out of 19 countries

– still with substantial room for improvement but ahead of the USA, which came in last in the most recent period (Figure 2). The NHS’s improvement in quality may be one of its greatest accomplishments, portending well for further improvements in health outcome measures, such as mortality amenable to medical care, in the near future.

Judging by the performance of other health systems, there remain areas for improvement. The UK ranks low on access to elective surgery and specialist consultations. However, waiting times have diminished, as



* Countries’ age-standardised death rates, ages 0–74; includes ischaemic heart disease.

Source: Nolte E., McKee C.M. (2008) Measuring the Health of Nations: Updating an Earlier Analysis. *Health Affairs* 27(1): 58–71.

tracked by Commonwealth Fund surveys. Waiting times fell dramatically from 28%, who reported waiting more than six months for elective surgery in the Commonwealth Fund 2001 International Health Policy Survey,³ to 15% in the 2007 survey.⁴

What changes are responsible for the improved overall performance? A main factor is the presence of national leadership and its dedication over the past 10 years to an overarching vision of what it wants the NHS to be: “a world-class NHS”.⁵ It is developing a coherent set of strategies to achieve a high-performing healthcare system, including a strong element of accountability. The willingness of national leadership to take on system-wide reform, rather than a more incremental approach, is a key factor in the UK’s improved health system performance.

Innovations in the UK health system are attracting outside interest. With the increased resources committed to healthcare, the UK instituted a new payment system for general practitioners, which has been watched closely within the UK and in countries such as the USA, which are considering a ‘Pay for Performance’ system of provider payment. While costing more than initial projections, the ‘takeaway’ for an American audience is that incentives work, but need to be carefully designed to avoid unintended consequences. The USA has not yet started national public reporting of physician clinical quality or providing payment

incentives for quality of physician care, so the UK leadership in this regard is a particular contribution to international learning. Other notable innovations of great interest to the USA include:

- the establishment of performance targets and national service frameworks – the USA has no system of establishing health system goals, setting priorities for improvement, establishing standards of excellence in service provision and tracking progress over time
- star ratings and, subsequently, the NHS annual health check – early efforts on public reporting in the USA informed the NHS programme. However, the influence went both ways as the NHS programme spurred the USA on to expand its public reporting to hospital quality indicators, including the recent addition of patient experiences with care
- patient voice – the NHS has been a leader in using surveys, such as those developed by the Picker Institute Europe for the Department of Health and Healthcare Commission to solicit patients’ views systematically on their experiences of getting care. The USA is publicly reporting patient experience and satisfaction data on hospitals through a federally-managed website, again with two-way benefits from learning across the Atlantic

3. The Commonwealth Fund. Commonwealth Fund International Health Policy Survey 2001. Available at: <http://www.commonwealthfund.org>.

4. The Commonwealth Fund. Commonwealth Fund International Health Policy Survey 2007. Available at: <http://www.commonwealthfund.org>.

5. Darzi, A. *Our NHS, Our Future*. Available at: <http://www.ournhs.nhs.uk/>

- NHS Direct – the USA has much higher use of emergency departments for medical problems that could be addressed by primary care physicians, and has no national system of off-hours care or telephone advice from nurses. The USA is exploring policy options to strengthen the primary care delivery system as NHS Direct has
- National Institute for Health and Clinical Excellence (NICE) – the USA is beginning serious discussions of an entity that would expand funding of research on clinical effectiveness and synthesise information to inform both clinical practice and insurance benefit design
- National Patient Safety Agency – eight years after publication of the landmark Institute of Medicine report, *To Err is Human*,⁶ the USA has few effective mechanisms for reporting or improving patient safety; states and private professional organisations have taken the lead in the absence of federal government action
- NHS Institute for Innovation and Improvement – while the USA has world-renowned exemplars, such as the Institute for Healthcare Improvement, the NHS is positioned advantageously to support evaluation, spread successful new ways of working, deliver

patient-centred care and transform healthcare system-wide.

Not surprisingly, from an American perspective the NHS has been an innovator in improving health system performance and provides a rich experience from which to learn. Despite years of under-investment in healthcare, the reforms of the last 10 years would seem to be addressing many shortcomings within the NHS, building on its underlying strengths and testing new innovations and organisational strategies for improving performance. Policy officials and experts from around the world will be watching the evolution and impact of these innovations as they move forward. As the NHS reaches its 60th year, there are significant achievements to celebrate, and which could well serve as systemic models of quality, efficiency and equity for an American healthcare system striving for its own higher performance.

6. Institute of Medicine. *To Err is Human*. Washington, DC, Institute of Medicine, 1999.

Val Gooding

Val Gooding, CBE, is former Chief Executive of Bupa.

The National Health Service is a much-loved institution and everyone connected with it over the past 60 years should be proud of its many achievements. The NHS has an important place in the nation's heart, and it still enjoys the support of politicians of all hues. However, this does not mean the NHS should stand still. After all, the service itself was a response to the specific needs and challenges of the 1930s and 1940s. Many people acknowledge that it needs to develop further to meet the needs and lifestyles of people in the 21st century.

Worldwide economic conditions dictate that any such development will need to be undertaken with more modest increases in resources than have been ploughed into the system in recent years. The NHS watchwords for 2008–12 are 'efficiency' and 'value for money'. As such, those responsible for the service are now looking around as widely as possible to see where they can gain new ideas and improve services for patients at the same time.

Bupa's 2006 *Mind the Gap* report¹ examined some of these issues. One potential funding solution is that those who can afford to pay contribute towards the cost of their treatment and services. Bupa's experience in the Australian

market has shown that where government support is provided, more people are encouraged to take control of their own health and wellbeing needs. Of Australians, 44% have health insurance cover in comparison to just 12% in the UK.

Over the past 10 years, there have been a number of welcome policy developments. We are seeing the establishment of strong NHS foundation trusts. These are bringing management and delivery of services closer to patients across the country. There is also an increasing desire to strengthen primary care services through new polyclinics to provide services that are more tailored to local needs. Independent sector expertise can make a huge contribution to the development of the NHS. The sector has many skills to share and is willing to do so. It exists alongside the NHS and does not seek to replace it.

Private medical insurers such as Bupa commission billions of pounds of medical care a year. The efficiencies they have identified and the lessons learned can be passed to NHS trusts and primary care trusts through schemes such as the Department of Health Framework for Procuring External Support for Commissioners. In many cases, the independent sector has the experience that may be missing from primary care trusts. One example is treating patients with complex conditions in their own homes. All of the above

1. NERA Economic Consulting (for Bupa). *Mind the Gap: Sustaining Improvements in the NHS beyond 2008*. NERA Economic Consulting, 2006.

can be delivered now through a partnership approach between the independent sector and the NHS.

Looking forward, Bupa would like to see not only closer working between the NHS and the independent health sector, but also greater collaboration and seamless delivery of care within the social care sector. That is why the next great challenge for the NHS is to integrate fully health and social care services from planning and provision right through to budgets. Getting that right would create the NHS Mark II: one which would be fit for purpose for the next 60 years.

David Green

Dr David Green is Director of Civitas.

The NHS has been a triumph of romance over results. When researching his history of The King's Fund, the distinguished historian Frank Prochaska, discovered that in the 1930s British voluntary hospitals were widely accepted as "the best in the world".¹ That phrase, or its variant, "envy of the world", has lingered on from the pre-NHS era. However, the reality is more prosaic.

In 2006, the Healthcare Commission asked the employees of all acute NHS trusts if they agreed with this statement: "As a patient of this trust, I would be happy with the standard of care provided." Only 42% agreed, 25% disagreed and 32% said that they neither agreed nor disagreed. In large acute trusts, only 34% agreed.² In 2007, staff in all acute trusts were asked whether "care of patients/service users is my trust's top priority." Only 48% agreed, 23% disagreed and 28% sat on the fence, neither agreeing nor disagreeing.³

The ideal behind the NHS has always been admirable. As a people we accept collective responsibility for ensuring that lack of money never prevents anyone who suffers the misfortune of ill-health from getting good quality treatment. But other civilised countries have the same

ambition and they have gone about achieving it in different ways. After 60 years should we be ready to admit that our way – a combination of state finance and public-sector management – is not the best? For example, a survey of 29 European countries, including all European Union members, by the Brussels-based Health Consumer Powerhouse ranked the UK 17th in 2007. Its Euro-Canada Health Consumer Index combines medical outcomes and consumer responsiveness in a single measure.⁴

For the last 20 years it has been widely accepted that the NHS could be much better, which is why reform has been constantly in the air. During the Blair years there was a big push for 'contestability', which has left a legacy of continued public-sector finance but with independent management of some services. Simultaneously, most hospital managers find themselves subject to close supervision through central targets. Over the same period, patients have been told that they are now consumers armed with choices that put them in the driving seat. However, people in areas where costly drugs are denied do not really feel as if they are in charge.

We should not be naive about the motives of doctors, as the gaming of targets and the Quality

1. Prochaska F.K. *Philanthropy and the Hospitals of London*. Oxford: Clarendon Press, 1992, p. 130.

2. Healthcare Commission. National Survey of NHS Staff 2006. Available at: http://www.healthcarecommission.org.uk/_db/_downloads/Q20-Q24_detailed_responses.xls.

3. Healthcare Commission. National Survey of NHS Staff 2007. Available at: http://www.healthcarecommission.org.uk/_db/_downloads/Your_organisation_.xls.

4. Health Consumer Powerhouse. Euro-Canada Health Consumer Index 2008. Available at: http://www.healthpowerhouse.com:80/archives/cat_media_room.html.

and Outcomes Framework amply testifies. However, medicine is not just a job – there are many doctors who still feel that it is a vocation. Their commitment has prevented the NHS from being worse than it might have been, but often it is the most dedicated staff who feel the most beleaguered in the current atmosphere.

The NHS at 60 is full of contradictions. The language of consumer choice coexists with the language of tight central direction of services. There is some contestability between providers and some space for private suppliers, but state finance limits their discretion. Moreover, the key service providers remain subject to both state funding and state management. Also, we have medicine as a vocation contending with an official management style based on manipulating the behaviour of subordinates with rewards and punishments. Above all, the NHS is too political. It should be depoliticised and re-professionalised. As John Stuart Mill realised long ago, the reason for competition is not merely to take advantage of the profit motive; it is to enlist the enthusiasm of providers in finding better ways of serving other people. Monopolists have no reason to think of anyone but themselves. Some say that we can overcome monopoly through administrative decentralisation, but Mill warned that, even if managers are carefully appointed on merit and subject to supervision by the public and a

well-informed press, they still lack sufficient interest in outcomes for consumers.⁵

In any system, public or private, there are potential conflicts of interest between third-party purchasers and patients, and between third-party purchasers and doctors. Both state purchasing agencies and private insurers will exert pressure on providers, perhaps through global budgets or clinical protocols. The difference is that a state monopoly purchaser has more control. Private insurers must compete to keep customers. Consequently, professional judgement can be safeguarded. A doctor who dislikes a private insurer's attitude can tell patients that the insurer is not providing a good service and recommend a change. Also, doctors can start their own insurance company – that is how some health maintenance organisations emerged.

For the doctor with a sense of vocation, competition provides a better safeguard of professional judgement than control by monopoly state purchasers. Competition and medicine as a vocation are natural allies.

5. Mill J.S. *Principles of Political Economy*. London: Longmans, Green & Co., 1909.

Chris Ham

Professor Chris Ham, CBE, is Professor of Health Policy and Management at the University of Birmingham.

The greatest achievement of the NHS is one that is easy to overlook. By introducing universal coverage and access to services that are largely free at the point of use, the NHS has removed the fear that used to be associated with the onset of illness: namely, how the costs of medical care would be met. For generations that have grown up with the NHS, it is important to remember this achievement and what would be lost if the founding principles were undermined – on which more anon.

The biggest challenge facing the NHS is how to adapt to the rapidly changing needs of the population. With infectious diseases such as tuberculosis having given way to acute illnesses such as heart attacks and strokes, only to be superseded by the increasing prevalence of chronic medical conditions, services are always at risk of tackling the problems of yesterday rather than those of the present and the future. Meeting current population needs requires action in four areas.

First, priority must be given to prevention as well as treatment. With increasing understanding of the importance of the risk factors that contribute

to the burden of disease, and the interventions needed to address these risk factors, progress in improving population health depends first and foremost on acting on the determinants of ill-health. While the NHS has a key role in prevention, other agencies are equally (if not more) important, underlining the need for cross-governmental and cross-sectoral action in this area.

Second, much more needs to be done to involve patients, carers and families in the prevention and treatment of illness. Particularly at a time when chronic medical conditions represent the major burden of disease, people with these conditions must be supported to manage them as effectively as possible, in partnership with clinical teams. The Expert Patient Programme and related initiatives have started to recognise this, but efforts in this area remain in the foothills, with the hard climb to the summit lying ahead.

Third, primary healthcare assumes even greater importance in providing the medical home for patients with chronic conditions, and the first port of call when they need advice and support. The NHS has a clear advantage over most other healthcare systems in this regard in having a well-established primary healthcare system that is valued by patients, and providing both continuity of care and coordination of care where it works at its best. The challenge now, as Nye Bevan would

have put it, is to universalise the best and ensure that all patients have access to high standards of primary healthcare.

Fourth (and in many respects the most difficult), the NHS has to find ways of achieving greater integration of care. In a world of chronic disease, the separation between primary and secondary care appears increasingly anachronistic, not least because patients need to be able to move easily between different services, depending on the progression of their condition and the ability of the primary care team to provide an appropriate response. Finding ways for specialists to work in the community alongside primary care teams holds the key to progress in this area, as less reliance is placed on hospitals, and care closer to home becomes a reality.

Assuming that progress can be made in these four areas, the big political question for the future is how healthcare will be funded. Health economists describe healthcare as a 'luxury good' that people want to consume more of as incomes rise. This applies to countries as well as individuals and households, with rich countries spending a higher proportion of gross domestic product (GDP) on healthcare than poor countries. With most healthcare funding in Organization for Economic Cooperation and Development (OECD) countries deriving from public sources such as taxation

and compulsory social insurance, will there be the political will to increase funding from these sources, or will private spending have to increase to provide some of the funds that will be needed in future?

To raise this question is to revisit the social contract on which the NHS was founded. In the post-war era, there was widespread support for the risk pooling and redistribution of income and wealth on which the NHS and other public services were based. Sixty years on, and in a society with different values and expectations, that support can no longer be taken for granted. Recognition of this has driven the Blair and Brown governments to take radical action to modernise public services such as the NHS.

Looking to the future, the willingness of the public to accept state restrictions on the ability of people to top-up public funding from their own resources is likely to come into question, especially if government spending fails to keep pace with rapidly rising expectations. As and when this happens, the social contract will need to be renegotiated, for example in relation to contested issues such as the funding of experimental cancer drugs and other treatments that the National Institute for Health and Clinical Excellence (NICE) has deemed should not be available under the NHS.

If individuals are willing to supplement NHS funding from their own resources to pay for these treatments, should they be allowed to do so, or would this be such a fundamental breach of the founding principles that it would undermine the commitment to equity on which the NHS was based? Alternatively, does our understanding of equity need to be revisited to take account of changing social and economic conditions? Might this mean guaranteeing a minimum standard of access to healthcare for all, while enabling those who choose to supplement public coverage from their own resources?

To even raise these questions is to risk antagonising the defenders of the NHS, who hold dear to the values that guided Bevan and his fellow architects. However, not to raise them is to risk adopting an ostrich-like response to issues that will not go away. Without pre-judging the debate, there needs to be an honest discussion of the future funding of healthcare, and the balance of public and private contributions, to ensure the survival of Britain's most cherished public service for the next 60 years.

It was Archie Cochrane who famously said that all *effective* healthcare should be free. Preserving that principle, while enabling individuals to top up what the NHS provides from their own resources, may be the only way of renewing the social contract for the 21st century.

Nicolaus Henke

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For almost 50 years, spending on healthcare has risen by two percentage points in excess of growth in gross domestic product (GDP) across all Organisation for Economic Cooperation and Development (OECD) countries. The trend is remarkably consistent, indeed startling. There have been minor fluctuations for short periods when countries have tried to restrict the growth of health spending. However, the growth rate has always reverted to trend and no country has sustainably limited healthcare spending to even a 1% 'excess growth' over GDP.

If current trends persist, by 2050 most countries will spend more than 20% of GDP on healthcare, and the USA will be spending well over 30%. By 2080, Switzerland and the USA will devote more than half of their GDP to healthcare, the position most other countries will reach by 2100. By then the USA would be spending 97% of its GDP on healthcare and the UK 63% – almost two-thirds.

That is difficult to conceive. In 1960, most observers would have said that 40 years on, it would be pretty inconceivable that Western

Europe would be spending on average 9% of GDP and that healthcare would become the biggest economic sector. However, of course, that prediction has come true.

Up to a point, committing a larger share of GDP to health as countries get richer is not a problem. The most convincing correlation in the whole of social science is the one which shows that the richer a country is, the greater the share of national income per head it spends on health, whether publicly or privately. So beyond a basic minimum, health is in fact a discretionary good. If an economy is growing, a larger share of a larger cake still leaves more actual money to be spent on other things. So health probably can continue to take a larger share of GDP for a while; however, it remains inconceivable that countries or individuals will allow it to get to 50% of GDP.

What might stop this? There are five things. First, younger people may balk at paying for older people's health costs which, after all, are the biggest demand on the system.

Second, there is a limit on how much anything can be tax-funded. Even the USA funds 59% of healthcare spend in one way or another via taxation, and the competition for budgets from funds raised via tax will not decrease – notably,

social care and pensions, but also education, defence and others – which may force a limit on health spending.

Third, in a world in which life expectancy is moving towards 100 years, later in the century people may perceive that the return for each extra marginal dollar spent on health may decline, reducing the incentive to spend more, whether publicly or privately.

Fourth, technology lowers costs in most other industries, and there are plenty of examples where it does in healthcare. However, over the last 50 years the story in health has been the opposite, one of supply (new treatment options) creating demand. Hugely transformational new technologies in the pipeline – including the trend not just to cure disease but improve the brain and motor functions of the body – may make this unlikely, but then it is possible that technology will raise productivity in a way that more than makes up for the rising cost.

Fifth, growing numbers of countries have gone, or are going, smoke-free in public places – something unimaginable 25 years ago. If social norms were to shift dramatically so that overeating and under-exercising became truly abhorrent, demand for healthcare could fall.

What are governments doing about this?

Generally, based on a recent survey of health system reforms in the major health systems, governments are pursuing seven themes on health and healthcare. The three major reform themes we see are targeted most often at tackling the ‘2% excess spend’: financing, productivity and quality. Financing reforms target the incentive to use services: they include co-payments, exclusions from reimbursement (both explicit and by stealth) and changes to who pays, with the changes going both ways (more employer-based and less employer-based). For example, Singapore reimburses 80% of the cost for eight-bed rooms and 0% for single-bed room use, and utilisation responds.

Productivity reforms attempt to increase provider efficiency. The most powerful productivity drivers in hospitals have been healthcare resource groups, which incentivise hospitals to get more activity and produce each case at lower costs. Increasing accountability, sometimes coupled with competition, is another lever many governments push, and hospitals drive this through by introducing the same ‘down-to-the-service’ lines as business did in the 1960s to 1980s by creating profit centres within companies.

Quality reforms mainly target to get a better result for the money spent already – an indirect way to get at productivity increases. The major reform themes here are better information about what the healthcare dollar achieves in outcomes for a population of an insurer, region or provider, and within providers in some cases down to individual clinicians or teams. Often, this is coupled with changes to professional or clinical leadership and incentives for quality.

Julian Le Grand

Professor Julian Le Grand is Richard Titmuss Professor of Social Policy at the London School of Economics. He was Policy Adviser to Prime Minister Tony Blair from 2003–05.

The greatest achievement of the NHS over the past 60 years is to have survived. Just think what has happened over that time: the economic decline of Britain in the post-war years; the oil price and fiscal crises of the 1970s; the economic hurricane and ideological blizzard of the Thatcher years; the collapse of the Soviet Union; and the general turning away from collectivism that characterised the 1980s and 1990s. Then think what has not happened: there has been no rolling-back of the NHS; no emasculation of its funding; no wholesale desertion of the service by the middle class; no flight into private insurance and private care; no collapse of the system under the intolerable weight of improved technology and rising public expectations; and outside of dentistry, no reversion of charges. Today, the NHS overwhelmingly remains the largest provider of healthcare in the country, and one with its central principle intact: that care should be available free at the point of use and accessible to everyone regardless of income, class, ethnicity, religion or gender.

Of course, there have been changes. The most obvious is size. In 1951, health spending was 3.5% of UK gross domestic product (GDP); by 2005/06, the proportion of NHS expenditure

in a much larger GDP had more than doubled to 7.4%.^{1,2} Another change is structure, at least of the secondary care side of the English NHS. This has moved from what was once a largely command-and-control organisation to a quasi-market with a diverse set of providers, of which foundation trusts and independent sector treatment centres are the most obvious examples, competing for custom from a diverse set of commissioners, including primary care trusts, practice-based commissioning consortia and contracted private-sector organisations. Command-and-control, even in its softer form of targets and performance management, is being replaced by patient choice and provider competition.

What of the next 60 years? Certainly, there will be challenges. There will be tabloid horror stories, equivalent to those of today about superbugs and dentist queues, and these will convince the public that the NHS is in a dreadful way and getting worse. Also, there will be what the Canadian health economist, Bob Evans, calls 'zombies': the corpses of long-dead ideas that periodically rise from the grave and stalk the halls of Whitehall and think tanks. So, every few years we can expect a think tank report, probably funded by an insurance company, arguing that a tax-funded NHS cannot possibly survive the pressures of expensive medical technology and public expectations, and that we shall have to introduce

1. Glennerster H., Hills J. *The State of Welfare* (2nd edn). Oxford: Oxford University Press, 1998, p.25, Table 2A1.

2. Office for National Statistics. *Annual Abstract of Statistics*. London: TSO, 2007, p.160, Table 10.22.

user charges. Groups of doctors will produce a series of pamphlets advocating NHS independence and social insurance. Politicians of both parties, worried at the surface turbulence of the quasi-market, together with civil servants and managers eager to reassert their power base, will be tempted to return to command-and-control – as indeed we are now seeing in Scotland and Wales.

However, I hope that in 60 years' time a largely tax-funded NHS will still be there, with most care free at the point of use, patient choice and a largely pluralistic system of providers. This should happen, not because an NHS with these characteristics is a perfect or even a wonderful system, but because, as I have argued elsewhere,³ of all the ways of running a publicly-funded health service, it is the least worst.

That said, I think there will be two areas whose future is far from clear. One concerns the divide between health and social care. The need for integrating both kinds of care for the elderly will become increasingly pressing, as the population ages and as the proportion of our lives that we spend in a disabled or unhealthy condition increases. For many years, everyone has acknowledged the need for integration, but because of institutional barriers (central versus local government, means-tested versus universal service, and so on), as well as other reasons, it never happens. Perhaps the drive for personal

budgets in social care could be combined with the idea of patient budgets for long-term conditions, which a number of us have advocated⁴ in a way that takes this forward.

The other area of uncertainty is public health. When I worked at 10 Downing Street, the only fights we had with ministers in the Department of Health were over public health, particularly the proposal for a ban in smoking in public places. Similar arguments came up again after I had left Downing Street when, in my capacity as chairman of Health England, I put forward the libertarian paternalist idea of a smoking permit, changing the default position so that someone who wanted to smoke had to 'opt in' to being a smoker by applying for a pass that would enable them to buy tobacco. In this case the tabloids, and some of the qualities, exploded in fury – as did my email inbox. For reasons that are not entirely clear, my green-ink emailers on smoking permits sent me innumerable pictures of Hitler (of which my 'Deleted' folder now contains an unrivalled collection). What is clear, though, is that the battle between the concerns of public health and fear of the 'nanny state' is far from over. Given the fact that the health risks of smoking, alcohol and obesity are acute and, at least in the last two cases growing sharply, it is the outcome of that battle which may be the biggest factor that will affect the next 60 years of the NHS.

3. Le Grand J. *The Other Invisible Hand*. Princeton, NJ: Princeton University Press, 2007, ch. 4.

4. Le Grand, *The Other Invisible Hand*, ch. 5.

Alan Maynard

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Discontent about the efficiency of the NHS has increased over 60 years. In the 1960s, the Minister of Health, Enoch Powell, remarked that the only thing that doctors would talk about was money. In the 1970s the then Secretary of State Barbara Castle published a report which highlighted variations in clinical practice and the scope for greater efficiency through, for example, increased use of day-case surgery.¹ In the 1980s, after initially failing to privatise the NHS,² prime minister Margaret Thatcher demanded demonstration of 'value for money' and, in creating the purchaser-provider split, expected greater rigour and efficiency in commissioning and providing healthcare.

Continued frustration with the inefficiency of the NHS led to very large investments in regulation during the Blair years. In addition to the National Audit Office, which reports to the Public Accounts Committee of the House of Commons, and the Audit Commission, which polices financial probity and service delivery in local government and the NHS, there are the Healthcare Commission, the foundation trusts' regulator Monitor, and the Department of Health. These competing regulators cost hundreds of millions of pounds. and together they publish volumes of advice, directions and performance reports. Their efforts

are complemented by the National Institute for Health and Clinical Excellence (NICE), which publishes mandatory guidance on technology and advice on treatment guidelines. The NHS Institute of Innovation and Improvement highlights potential efficiency gains from reducing clinical practice variation, with advice reminiscent of Barbara Castle's in 1976.

Unsurprisingly, this lack of success in mitigating well-chronicled inefficiencies in delivering patient care in the NHS causes frustration among politicians, policymakers and radicals in the medical profession. The expense of regulation and the at-best modest successes of the plethora of agencies involved in policing and performance-managing primary care trusts and providers is increasing the attraction of financial incentives.

Most exchanges, whether between institutions such as primary care trusts and hospitals, or between employers and their staff, have to be based on trust. Contracts to deliver healthcare or labour services can never be complete. However, trust is clearly undermined by the poor performance of providers. The fashion now is to believe that financial incentives are the solution to the problem of inefficiency.

This may or may not be correct. Financial incentives are very powerful, and they can have benefits and costs. The 2004 general practitioner

1. Department of Health and Social Security. *Priorities for Health and Personal Social Services in England*. London: HMSO, 1976.

2. McLachlan G., Maynard A. (eds). *The Public-Private Mix for Health: The Relevance and Effects of Change*. London: Nuffield Provincial Hospitals Trust, 1982.

(GP) contract introduced a Quality and Outcomes Framework, which incentivised increased provision of chronic care. Many of these interventions had a robust evidence base but were not being routinely provided by GPs. This omission created avoidable mortality and morbidity.

Rather than vigorously enforce the existing GP contract, more than £1.7 billion was invested in the Framework and GPs' salaries rose by 58% in three years, as their hours of work continued to decline.³ Nurse substitution facilitated high levels of Framework target achievement. This was an expensive way of getting GPs to provide what they should have been providing anyway. It has made practice more transparent and, with revision, may have a considerable impact on population health. It contrasts nicely with the reform of the consultant contract. This increased payment levels considerably but exacted no *quid pro quo* from providers, even though there is good evidence of large and inefficient variations in clinical practice.^{4,5}

The national and international literature on 'Payment for Performance' is increasing, but evaluation is slight. Thus the potential to harm patient care at considerable cost is rising.^{6,7}

In England, hospitals that fail to reduce their infection rates will be fined considerable sums. From October 2008 in the USA, under Medicare, the large federally-funded programme for the elderly, hospitals that perpetrate medical errors on their patients will be paid for the admitted condition, but not for the consequences of hospital errors. For example, if a patient is admitted for pneumonia and poor care gives them a catheter-induced urinary tract infection, the hospital will be paid for the pneumonia care, but not for treating the infection. In addition, Medicare is paying bonuses to high-performing hospitals. This system focuses on five conditions: acute myocardial infarction, heart failure, pneumonia, coronary artery bypass graft and hip and knee replacements. For each of these conditions there is an array of process and outcome-mortality quality measures. Those hospitals in the top decile of performance get an additional 2% of revenue, and those in the next decile an additional 1%. Those who are in the lowest decile over three years face budget cuts.

The issue is whether small bonuses or small penalties are the best way of altering behaviour. Prospect theory⁸ predicts that small-income loss is a more powerful motivator than larger

3. National Audit Office. *NHS Pay Modernisation: New Contracts for General Practitioners in England*. London: National Audit Office, 2008.

4. Bloor K., Maynard A. Consultants: Managing Them Means Measuring Them. *Health Service Journal* 2002; 112(5836): 10–11.

5. Maynard A., Bloor K. Consultant Clinical Activity Is the Key to Improving Productivity. *Health Service Journal* 2006; 116(6013): 18–19.

6. Rosenthal M.B., Frank R.G., Li Z., Epstein A.M. Early Experience with Pay for Performance: From Concept to Practice. *Journal of the American Medical Association* 2006; 294: 1788–93.

7. Maynard A. *Payment for Performance (P4P): International Experience and a Cautionary Proposal for Estonia*. Estonian Health Insurance Fund and the World Health Organization (Europe), 2008.

8. Kahneman D., Tversky A. Prospect Theory: An Analysis of Decision under Risk. *Econometrica* 1979; 47: 263–92.

gain, especially if this affects reputation. A nice inference from this is that the current system of clinical excellence awards, essentially a highly remunerative system of 'performance'-related pay for consultants, should be complemented by a system of 'demerit' awards or small-income losses for poor performers.⁹

Clearly, the current inefficiencies in healthcare systems, both public and private, are intolerable. Their erosion may be facilitated by 'Pay for Performance' schemes that are carefully designed and implemented. Such schemes require good comparative activity, cost and patient outcome data; hopefully they will be piloted and evaluated carefully. Without such an approach, the capacity of 'Pay for Performance' to damage patient care may become very evident. The challenge for the next 60 years of the NHS is to remove self-evident inefficiency by careful deployment of financial incentives that complement professionalism and public trust.

9. Bulstrode C., Maynard A. Merit Awards: Could Work Both Ways. *British Medical Journal* 1994; 308(1165).

David Mobbs

David Mobbs is Group Chief Executive of Nuffield Health.

Shortly after the NHS reaches the age of 60, it will get its first constitution. If this is handled well, it could bring clarity to rights, responsibilities and objectives and ensure that the service remains as relevant and loved in the next 60 years as it has been to date. In announcing the NHS Reform Bill in Parliament in May 2008, the prime minister said that the new Bill will equip the NHS to focus care on prevention as well as treatment. On the face of it this seems eminently sensible, but I wish to sound a note of caution.

For six decades the NHS has done a remarkable job of fixing us when we are broken. It has played a major role in the social and economic revolution in this country: it has kept our workers working, eradicated childhood infections such as measles and mumps and delivered generations of healthy babies. However, partly as a result of this success, health needs have changed dramatically. In particular, issues driven by lifestyles and lifestyle choices are on the rise: poor diet, excessive alcohol consumption and lack of exercise are increasing people's risk of developing a well-documented range of serious conditions requiring long-term treatment and management.

Some would argue that the NHS has failed to adapt to the universally acknowledged truth

that prevention is better than cure, cleaving instead to a hospital-centric model of diagnosis and treatment. To give credit where it is due, good progress has been made in enabling earlier diagnosis and intervention and the management of chronic conditions. However, the overwhelming majority of people ignore the NHS until they are ill, at which point they go to see their general practitioner (GP). Unfortunately, this is not a good model for addressing issues driven by lifestyles and lifestyle choices.

So what can the NHS do? In my view, the NHS must continue to excel where it can and be brave enough to step back from doing the things that it may never do well. This does not mean that the Government or Department of Health can abdicate public health responsibilities; rather they must recognise that, in terms of service provision, the NHS cannot be all things to all people, and that the ability to embrace a diversity of other models will be essential.

Countless public health initiatives have taught us that people simply do not respond to official entreaties to live healthier, more virtuous lives. People will not eat well, exercise and give up smoking because they are told to – they will change when they want to. In short, the state does not do behaviour change well, but the market might. When you treat people like consumers rather than patients, it is possible to

bring about real step-changes in behaviour. For example, Nintendo's Wii Fit is a phenomenon – probably the fastest-selling home fitness device ever, shipping 338,000 units in its first two weeks in April 2008. Being a computer game, it has the potential to get the whole family involved, and has attracted many people who were not previously regular exercisers.

Health can be fun and motivating. However, these are not words that sit very comfortably with public health initiatives or the NHS. I am quite certain that computer games are not a serious long-term solution to getting the nation healthier and more active, but the point remains valid: if the NHS is going to succeed in engaging people in their own health, it will need to work with a whole range of partners and let some other people do the innovative thinking.

Understanding consumers and configuring services to make them want to change is what commercial organisations do well. Providing a comprehensive safety net is what the NHS does well. If the two are brought together, we might just make an impact. The independent sector at least has the advantage that it has always had: to serve people who have a choice. Not just a choice of provider, but a choice about whether to have a preventative health screen, whether to join a health club, whether to follow a diet and fitness regime, and so on.

In 1948, the notion of the health consumer would have been ridiculous. Health was not a matter of choice. Disease and illness happened and health professionals intervened. But those first generations of NHS babies – the baby boomers – comprise today's relatively affluent middle-aged consumers, and they are demanding something quite different. People want to look good and feel positive; they want to delay the ageing process; they want to remain active and independent throughout their lives; and when they encounter problems, they want quick and effective treatment. In many cases the lifestyle choices that people make are at odds with these needs, but the needs remain all the same.

In the era of choice, we have a real chance to bring together the best of the state and independent sectors to provide people with a seamless series of services designed to maintain and improve health, assess and contain disease, and provide first-class treatment when it is needed.

That is precisely the vision we have set out for Nuffield Health (the new name for Nuffield Hospitals): integrating services around the consumer's needs from health clubs to hospitals. Other new ideas and a few leaps of faith will be required, but in embracing many ideas from many different providers, the NHS may find a vision for Britain's healthcare fit for the next 60 years.

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Lord Adair Turner

Lord Adair Turner, Baron Turner of Ecchinswell, is Chairman of the Government's Committee on Climate Change. He is also Chairman of the Economic and Social Research Council and Chairman-designate of the Financial Services Authority.

At one level the NHS has been a huge success. I think the thing to do is to compare it internationally. It has given high-quality healthcare to many people – in some areas, absolutely excellent in terms of its emergency response and some of its tertiary care.

Compared internationally, the UK in health results clearly is not the best healthcare system in the world, but it is a good one. It does not produce the health results that one seems to get from, say, Sweden or from France. On the other hand, it has been among the cheaper systems. In terms of what it's got for what it's spent, it has probably been a reasonable result. The core of the system up to 2000 was one which cost less than it might otherwise cost, essentially because supply had been deliberately constrained. The inevitable result of that was that bits of the system were rationed by queueing, or were rationed by the implicit rationing decisions of the medical profession.

The worst of that was long queues for not immediately critical, but in some cases potentially life-threatening, conditions for some heart

conditions and some cancer – plus high queue lengths for things which were not life-threatening but extremely annoying and unsettling, such as the whole of orthopaedics.

It was quite easy to understand what the problem was up until the Labour party committed a lot more money to it, and there was a strong *prima facie* case that we ought to give it more money. We were behind other countries in terms of the amount that we spent. The big issues are: 'Did we change it enough as we gave it more money?' and 'Were the dimensions of change that we were debating the correct dimensions of change?'

The debate about whether the extra money over the past decade has delivered enough 'reform' fails to distinguish two things which we needed to think about as we gave the system more money: one short-term, the other long-term, which we need to debate as well. The short-term one was: if you gave this system a lot of money very quickly, was the supply-side capable of responding very quickly? And the broad answer was 'No'. The fact is that the supply of new doctors depends to a degree on what is happening in the medical schools. The supply of nurses depends on the nursing colleges. The supply of consultants depends on how many senior registrars you have coming up to consultant rank, and so on. If you give it a lot of money very quickly, and if what you need is more of each of these people, the system

simply cannot deliver them in a hurry because there are only so many of them. You can bring some in from overseas, but there are limits to that.

So, in economic terms, what gives is the price. I think the big thing which did not get thought through enough was the pacing of the increase of financial resources relative to the feasible maximum response of the supply-side of the NHS economy. That argued (as indeed Derek Wanless hinted at in his report) for a slower pace of financial build-up. There was not enough integrated thinking about what you really have to do – which is, first, increase the number of places in medical schools with a pre-commitment that the financial budgets are going to increase five years after you have increased the number of places in medical schools, and so on. Amid all the attention on foundation hospitals and ‘money follows the patient’ and choice and competition, somewhere in the middle a straight bit of manpower planning got lost.

So, seven years of 5% growth in real terms for the NHS – or something like that – might have been a lot better than five years of 7%. It would have been much less inflationary and we would have got more real healthcare response rather than medical inflation. I say this as someone who has a daughter at medical school, so that at one level personally, I am perfectly happy that doctors’

pay has increased so significantly over the last five years!

The other thing that gets missed is the overall balance of secondary care versus primary care. Of course, if you believe that markets are perfect, you believe you will get there in any case. Markets will deliver the optimal answer, but I think there is an issue as to whether you will.

I was very struck when I went with Simon Stevens on a visit to the United States, in the middle of the work I was doing, to Kaiser Permanente. On the one hand you had the assumption which goes back to Alain Enthoven’s Nuffield Trust paper¹ that markets would work. On the other hand, you had the *British Medical Journal* article, which was how much better Kaiser did than the NHS.² When you go and visit Kaiser, you discover it is not remotely like our market structure. It is actually a totally vertically integrated system. It is subject to the competitive challenge of having to compete with other providers, but of itself it is not a system where primary care or anybody else contracts with secondary care. It is an integrated primary and secondary care system. So what is obvious when you get to Kaiser is that there is a very different balance of secondary versus primary. Primary feels different. They have bigger practices. They have more equipment. They have more immediate access to X-ray, to ECG, to pathology, and soon all

1. Enthoven A. *Reflections on the Management of the National Health Service*. London: Nuffield Provincial Hospitals Trust, 1985.

2. Feachem R., Sekhri N., White K. Getting More for Their Dollar: A Comparison of the NHS with California’s Kaiser Permanente. *British Medical Journal* 2002; 324: 135–43.

of that happens quicker, and there are specialists from the hospitals in the primary care. When you look at why Kaiser has lower costs for its results, the crucial thing is: fewer people go to hospital. Fewer go there because more of them are dealt with at the primary level, and because fewer go, it means they do not catch things in hospitals. One of the things – which I think it was Nigel Crisp said to me (and it is a key insight) – is that you do not want to go to hospital. There are a lot of sick people there and you will catch things from them. However hard we try, these large hospitals with lots and lots of sick people together will tend to generate the latest variation of a bug.

So there is a need to think about what is the appropriate configuration of what happens in primary care, what happens at district general hospital, and what happens at the tertiary level. I am not convinced that you can be absolutely sure that we will get there by the contestability mechanisms that we have set up. In economics, it takes one back to the fundamental thinking about the theory of the firm, which is related to an economist called Coase. This asks: 'When is it most efficient to do things by market contracts, and when is it most efficient to do things within an integrated command-and-control system?' A firm is a thing within which you use command-and-control, and outside of which you use market relationships. It is not clear to me that you will

necessarily get to the model of integrated care that you want by setting up market relationships.

I remember putting a slide up for the report I did for Tony Blair, saying this could be the idea, but we're not going to get to it because of the nature of British politics. It followed a visit to Copenhagen county in Sweden [where the counties largely pay for care] and we were sitting with the head of the local medical system who said, "I've asked the mayor to come along because she pays for what I do." If one could sweep it all away and start again, one might have 20 or 30 blocks of people of 2 or 3 million, which is enough to get economies of scale, but small enough that they're manageable – with lots of compare and contrast between them, and with willingness to use the private sector – but with the core being these reasonably vertically-integrated groups where you can think through what healthcare means. However, you can only do that if you have vibrant local government.

So I remember putting it up and saying this might be the optimal solution. The NHS is clearly too big to manage centrally. The appropriate decentralisation, in an ideal world, might be to use vibrant units of local government that would allow real local accountability, but which would allow compare and contrast between them. But we can't get there. So given that we can't, what

should we do? Well, a lot of what we're doing. It is important to realise, when one talks about the role of markets, to separate what the health system does into manageable chunks. There is a subset of what hospitals do, which is particularly the pre-booked elective event susceptible either to internal or external markets. You can make some measurements of quality, of occurrence, of cost – you can get contestability, you can have competition, but there's a big chunk which is not susceptible to that. There's probably 40% or 50% of it which is either an emergency or a quasi-emergency – the whole of what goes on in medical assessment units, and in the blue flashing-light end of emergency, where you've got to accept that what you're managing is a natural local monopoly.

If all they ever did was hip replacements and eye cataracts, which turned out to be non-complicated, we'd organise the thing round a market, because that would be the logical way to organise it. If all that they did was blue flashing-light emergencies, we would never have debated having a market: it would be damned obvious that it would have to be a local monopoly, and we would work out how to manage it to best effect.

The trouble is that it is a complicated mixture of these things. The bit which is most clearly marketable is the pre-booked and relatively predictable elements but, of course, they

sometimes become unpredictable during the course of the event – the minority of the eye cataract operations or the orthopaedics that go wrong. So that makes separating them difficult.

Looking ahead

All that said, clearly the NHS has got better. Clearly, the waiting lists and the waiting times have come down, but you have to look at the political dynamics of satisfaction. We do have to realise that there is a potentially relentlessly rising demand. I think, basically, as people get richer, they reach a sort of satiation in how many washing machines they have, or how good their television is or how many clothes they can buy; but as best we know, there's no limit on how much they want to spend on healthcare. The American system, I think, has huge inefficiencies in it, but it is also a rich society which spends a lot on healthcare. It is probably spending about 15% or 16% of GDP [gross domestic product] on healthcare now. I think it's quite possible that in 20 years they'll be spending over 20% on healthcare. I think it's quite possible in 30 years they'll spend 30% on healthcare. I think our healthcare expenditure will go up – and it isn't simply an ageing society; it is that at every age group they demand more of the healthcare system. So we have to come to terms with the fact that healthcare may rise relentlessly as a percentage of GDP.

In the long term, that requires us to debate whether we can stick forever to tax-provided, free at the point of provision. I've never been convinced that there is some great advantage in insurance-based systems. That is not a conclusion that I think you would logically reach from looking at the American system, or even at the French system. So I don't think that the argument of moving away from tax-funded to insurance-funded is posited on some great extra efficiency of insurance-funded, but I do think that if healthcare expenditure goes to 15% of GDP and higher, you then have to ask whether it is sustainable to do it all from tax funding, or whether you have to think about, for instance, a co-payment system as well. Because we haven't reached that point yet, we've managed to avoid that debate – but at some stage during the next 20 or 30 years we will reach it, simply because I don't see there is any logical upper point of healthcare expenditure. Up to a certain point, people are willing to say, "This is an expenditure which I am willing politically to be taxed for and to be provided for everybody free", with an implicit redistribution in there – but suppose it was 60% of GDP? You'd have some people saying, "Well, some of this is a discretionary expenditure and people are entitled to different points of view on the discretion. Some people want to spend 80% of their income on health and some people want to spend 30%, so it shouldn't be taxed."

So it's not that we should regret at all the fact that expenditure will go up. I think that's inevitable, and I think it's perfectly sensible. It's just that when it pushes up beyond 10, 11, 12, 13, 14%, I think the ability to say, as a society, 'OK, that's fine, but that simply means that the general tax burden has to go up from 41 to 42, to 43, to 44, to 45% of GDP' becomes something that people will challenge. They will challenge it precisely because, beyond a certain level, it does feel discretionary: that some people want to keep driving for higher and higher health and other people don't. That, of course, creates tricky issues. If you try and trim the edges by saying some things are clearly discretionary, so everybody would agree that we're happy for these to be subject to co-payments or to Oregon-style rationing – well, actually when you do those lists, you don't get much. Everybody says carve off cosmetic surgery, or carve off Viagra, and you don't find you've carved off a lot. What it does come down to is drug treatments for depression, drug treatments for back pain, drug treatments for whatever.

I think everybody is probably going to end up with an element of means-tested co-payment. Beyond a certain level, one simply says one needs some private contribution as well, because people will prefer that to a pure total tax system. People will still feel that the vast majority of the things which richer people will be able to afford ought to be available to others as well. But I think the deal

which says it's absolutely totally free for everybody will come under some strain at some level of total expenditure as a percentage of GDP.

We're not anywhere near there yet, and I think the decision which was made to increase spending over the last five years was a reasonable one, a necessary one – and I don't agree with the idea that it would have been right to switch at the same time to an insurance system. My concerns are that, amid the fascination with foundation hospitals and quasi-markets, there was not enough interest in manpower planning and flow, and the ability of the system to respond. Some things that have happened will be very difficult to reverse.

We ought as a public to have got more 'bang for our buck' from the consultant contract and the GP contract, but in the public sector it is very difficult to say, 'Well, now we're going to try and renegotiate the contracts to get back to where, in an ideal world, we'd have been when we first negotiated them.' It is very difficult to retro-fit those things once you've gone wrong in the first place.

There should be further improvements. The money is there and it ought gradually, over time, to buy more. At least it ought to buy cleaner wards. Nicer looking wards. Getting rid of same-sex wards.

All that stuff which people care about a hell of a lot, actually – and more equipment. Doing that off a higher base must buy some long-term benefit.

Andrew Vallance-Owen

Dr Andrew Vallance-Owen is Group Medical Director of Bupa.

I have been a passionate advocate for the NHS since I first joined as a house officer in 1976. I soon became active in the British Medical Association (BMA), and our constant lobbying position in those years was for better NHS funding, so the Labour victory in 1997 was very exciting, and the better funding did eventually follow. The BMA only played a small part in that decision by Tony Blair but, thanks to their contract negotiations, they played a large part in seeing that a significant amount of that money has been spent on doctors. However, sadly, this has been with little positive impact on productivity or on improving health so far. Now a significant funding gap is developing again and the long-term even medium-term future of the NHS as a wholly tax-funded system, largely free at the point of use, must be in doubt.

While I believe that the period of improved funding has been a success for the NHS, I also believe that the money could have been used more wisely and that the apparent ongoing disillusion of the clinical professions, despite better remuneration and shorter working weeks, has to count as a failure to date. Re-engagement of health professionals must be a key target for Lord Darzi's review, but the leadership of these professions could do a lot more to show the

opportunities that local engagement could bring, to move the cost-efficiency culture towards a cost-effectiveness culture.

In 1980 I spent a year in Melbourne and was particularly impressed by their clinical audit, which was a routine process in the hospital there. I have encouraged clinical audit, covering both process and clinical outcome, ever since. I became medical director of Bupa's hospitals in 1994, and one of the worst days in my career occurred after we transferred one of Mr Rodney Ledward's patients to the NHS with complications after a hysterectomy, and she died. The balloon went up in both the NHS and independent sector and eventually, Mr Ledward was struck off the medical register. I reviewed his clinical data in our hospital and discovered that he had had no deaths, no readmissions, no complaints and only one or two re-operations. All the complications we now know about had been referred to other hospitals and we had no idea about the problems; it was then we decided that we needed to follow up our patients after discharge, and thus started our outcomes programme.

It seems extraordinary that we still do so little to measure success routinely in healthcare. Of course, mortality, infection rates, readmissions, complaints and adverse incidents are vital to our audit and learning, but routine measurement of patient experience and patient-reported outcome

is important too, both to encourage continuous quality improvement and to enable more informed choices to be made by patients and their GPs. Generally, productivity is measured as input versus output (payment by activity): but surely in healthcare, it should be input versus outcome (true payment by results)? If the profession took up the cause it would be putting patients back in the centre and would have a real tool to counter the cost-efficiency culture it dislikes so much.

Another significant change over the last few years has been the greater involvement of the independent sector. When I joined Bupa, the private sector was quite separate from the NHS and, when they came to power, Labour ministers openly stated that they were only responsible for, and interested in, the NHS. However, that view changed during the winter beds crisis of 2000, after which a concordat was signed; then along came the independent sector treatment centres. Ostensibly, all this was to help reduce waiting lists, but the initiative was designed also to galvanise acute trusts to respond to the threat of the centres pinching 'their' patients by improving their service and efficiency. Both objectives were achieved in part, but at the expense of huge political difficulty for the Government.

Now the attention has moved to independent sector involvement in commissioning. This seems to be more welcome because, instead of

being parachuted in by the Department without consultation, primary care trusts themselves are seeking support from private companies, which is a much better starting place. So far, the jury is out on whether the private companies can deliver, but I believe that many will, and that primary care trust commissioners are going to need this type of support for some time if they are really to drive towards world class commissioning.

Commissioning has great potential but is yet to tackle the dominance of secondary and tertiary care in our healthcare system. We need much more emphasis on, and funding for, health promotion and self-care to help tackle the epidemic of obesity and chronic disease which is coming down the track (employers also should have a major role in this). Later in life, we must have better funding to support the elderly – the funding that local authorities have for this type of care is woefully inadequate at present and relentless demographic change will only make things worse. Finally, we have to tackle the great divides between health and social care. As well as better prioritisation of funding to respond to the wider needs of communities, new thinking is needed to develop more integrated approaches. There are examples of these where the doctors work in harmony with good results – for example, in organisations such as Kaiser Permanente in the USA. In the future we need to engage with these issues, and to pilot new approaches.

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