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EDITORIAL

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# EDITORIAL—the NHS at 70: National treasure or threadbare antique?

Since the British NHS reached its 40th anniversary in 1988, there has been a reckoning every 10 years. Actually, there have been more informal reckonings much more often, at least in England, where there seems to be continual moral panic about the financial and political sustainability of the service.

In 1988, Margaret Thatcher's government's latent hostility to the NHS and resultant reforms brought skeletons to the birthday feast. In 1998, the 50th anniversary was much more upbeat. The new Labour government of Tony Blair had promised to save it and had not yet launched its own half-baked reforms. The 60th anniversary in 2008 was less upbeat but nothing like as pessimistic as the current 70th in 2018, which is borne on a wave of financial crisis and sparse care, again in England at least.

So is crisis an inevitable accompaniment to an ambitious service which prioritises equity, still offers efficiency despite torrents of inefficient reform, again, in England at least—yet offers variable clinical quality and dubious user convenience? I use this last phrase rather than consumer choice, as the latter reduces the user experience to choice of hospital at time of illness, which successive reforms have expensively rendered either illusory or trivial.

Clearly *political* crisis is not inevitable for the NHS. Alleged crisis is continual in England, at least among the chattering classes mostly but not exclusively on the Right, but usually absent in the other countries of the UK, with the partial exception of Wales, where lack of money and complacent parochialism has caused problems until recently at least. In Scotland, Northern Ireland and Wales, however, angst about the NHS is not accompanied by a loss of belief in it.

Economic crisis, or rather *fiscal* crisis, is the consequence of subjecting the NHS to "boom and bust", which former Prime Minister Gordon Brown claimed to have abolished in the wider economy in perhaps the most egregious example of fate-tempting in recent British politics. The lean years under Thatcher and her successor John Major gave way to the bonanza of Blair and Brown, some but not all of which was wasted, and then the ice age under David Cameron's coalition government and then the subsequent Conservative governments, following the economic crisis beginning in 2008 but continuing after the amelioration of the economic outlook.

There is nothing intrinsic about fiscal crisis. Latter-day so-called Marxists who are desperate to paint a generous welfare state as incompatible with capitalism are living in the nineteenth century while using twentieth century jargon. Others point to "austerity" as destructive of the NHS, despite the fact that even leftist commentators such as former Greek Finance Minister Yanis Varoufakis rightly point out that there is not austerity in the UK by any reasonable yardstick.

Nevertheless, the way in which the different objectives for a successful NHS have collided with politics has given a good impression of inevitable crisis. Let me explain. The following argument applies to England, not the rest of the UK where the NHS has been governed locally.

Let us assume the four main objectives of the NHS (not in order of importance necessarily) are equity, efficiency, quality of care, and user-friendliness or user convenience. Different reforms over the last 30 years have been geared to tackling at least one of these, but often with counter-productive results. Thatcher was seeking economy and efficiency, which of course may sometimes be in opposition. Blair was seeking a more consumer-friendly service, in line

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with his “Third Way” approach of rejecting state centralism as well as unregulated markets. Subsequent governments were merely trying to manage but were retarded by the illiterate distraction of Health Secretary Andrew Lansley's reforms, begun in 2010 and producing re-dis-organisation (the term of the late Alan Maynard) without benefit.

Constant reform and upheaval require centralisation and performance management if to be combined with equity and cost control. Ambitious consumerist objectives require tight management if they are to rendered compatible with financial control. Market reforms and centralist performance management therefore became indistinguishable.

The problem for the English NHS as a result has been that, in pursuit of a more modern patient-led service, the opposite has often resulted. Trying to square the circle between market forces led by the consumer and state control of finance and performance has stymied the former and made the latter more bureaucratic and burdensome for the patient.

Some examples follow.

The General Practitioner services are in the dark ages due to poor or failed investment in information technology (an example being the horrendous failure of the Bair government's IT reforms). Patients cannot be “dual registered”, which would allow students for example to use both their home and university services without a bureaucratic process every time. Yet the GP services are now supposed to manage the health of their patients in the round, including health promotion and screening, which comes at the cost of ever shorter and less accessible “care and cure” regular appointments.

Mental health services emphasise talking cures over drugs, which is both politically correct and cheaper—but often useless or inadequate. Mental health care is under-resourced and often hopeless when it comes to emergencies.

There are not enough hospital beds, in the absence of a wholly revamped community service for which there is simply inadequate investment and too much short-termism in funding.

GP/hospital links are also in the dark ages, with even the simplest test results taking a long time or going missing, due to both hidebound attitudes and inadequate or inappropriate use of modern technology.

The obsession with cost recovery has bred a monster known as the NHS Business Services Authority (NHS BSA), which harries individuals over means-tested medicine prescription charges often with faulty information. Any attempt to seek redress leads to a classic case of “computer say no”: individuals are assumed to be guilty and have to prove their innocence.

Staff are working under ever more fraught conditions. The NHS is no longer a happy place to work, and the erosion of staff goodwill is a major cost for the future. Chaos in emergency rooms co-exists with more leisurely conditions in preventive programmes. This is not the fault of the staff in the latter. But it creates grievance.

Where producer cost or convenience clashes with consumer choice, the former wins—it has to, given the tightness of finance. An example is phlebotomy: in a topsy-turvy logic, patients who book in for a blood test earlier often have less choice of time-slot than those booking later. The reason is that, if there is little demand and the clinic has to be shortened, the early bookers have to take the first time slots. Rational for cost-control, but inconvenient for patients/consumers.

I could continue. But the overall point is that, increasingly, performance management within tight budgets co-exists with means testing. The latter is hitherto confined to the tiresome but relatively trivial procedures of the NHS BSA. But in the future as health care and social care are “combined” (sounds good but watch the small print), then means-testing may well seep across the border from social care to health care. For that border is often quite arbitrary. And the NHS in England has had to create a special programme—Continuing Health Care—to mitigate the worst costs of complex health care in the community (ie, outside hospitals but very likely in a “care home”) which used to be delivered in NHS facilities such as community hospitals and NHS nursing homes, now closed.

What all this means is that the disadvantages of an overly bossy state system are increasingly being combined with the disadvantages of an inadequately competitive private system. Think the Private Finance Initiative; poor competition for contracts for hospital and post-hospital care yet expensive tendering processes; and cost-recovery bureaucracy.

While President Donald Trump was characteristically misinformed about the demonstration demanding a better NHS in London in February 2018, he unwittingly put his finger on the problem of an increasingly bossy service which puts a premium on cost-utility: irrespective of how much one has "paid in", the care one needs may not be available.

Now we all know that in the USA, rationing is done by price and affordability, which is not the answer. But the NHS has to allow what the French call "la medicine liberale" rather than merely become a desiccated calculating machine. Even at the beginning of the fiscally generous Blair government in 1997, former Socialist French Health Minister Bernard Kouchner warned then-junior Health Minister in England, Alan Milburn, that real choice meant more generosity in the state system. This was an early echo of Trump's ill-thought-through but instinctive sense that the NHS may not suit those who expect payback for what are surely public insurance payments, and who expect convenience.

Ironically, the more anti-statist reforms are pursued, the more state bureaucracy mushrooms. So where does this leave us?

Market reforms within state health care systems are likely to be ineffective and also costly. There is a stark choice between state health care, prioritising equity, and private health care, prioritising convenience for the user but deficient in equity defined as equal opportunity of access for those with equivalent needs. No "Third Way" can alter this.

But there is some hope. If trusting professionals can be combined with leaner but more intelligent performance management of the system, then the NHS model can combine equity with an adequate degree of responsiveness, if funding is adequate. The best practices in Scotland, which has eschewed England's counter-productive reform mania, point to this. Note I say the best in Scotland. Overall, all the UK suffers from the above tendencies to the extent that limited finances and illiterate "government by target" dominate.

The jury is out as to whether the NHS can secure enough finance and combine decentralised freedom with good performance and outcome in order to flourish. Agreeing a financing model which takes annual funding out of politics —such as GDP growth plus 1%?—could help a lot. Gearing "reform" to the real problems at the coalface rather than politically-sexy macro-solutions would also help.

But in the end, it may be that consumerism is too strong for an inadequately responsive NHS. That is where Tony Blair came in. His diagnosis of the political need was spot on. Tragically, his reforms and their implementation worsened the malady.

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