National Health Service or National Health Business? an historical perspective

Dr Edward H Reynolds is a former consultant neurologist to the Maudsley and King's College Hospitals, Epsom Hospital and The Old Cottage Hospital Surgery, Epsom. He is now honorary senior lecturer in the Department of Clinical Neurosciences at King's College London.

In 54 years in the frontline at tertiary, secondary and primary levels I have experienced the best and the worst of the NHS.[1] It is crucial to understand that the current much publicised problems and challenges facing the NHS are not new, but can be traced to the early 1990s. The National Health Service and Community Care Act (1990) ushered in a profound change in NHS structure and culture, marking the point when best service practice was subordinated to best business practice. In a nutshell, the NHS became the National Health Business (NHB). This led to the fragmentation of healthcare, the rapid expansion of an enormous bureaucracy and constant strains between frontline staff and management at all levels.

The NHS – before and after 1990

In the early and mid-1990s ward closures, bed shortages, bottlenecks, cancelled operations, and lengthening waiting lists were as common as they are now. Who can ever forget the patient with a head injury who, in 1995, was helicoptered from Kent to Leeds, where he died soon after arrival, because there was not a single available intensive care bed in the whole of London and the south of England.

This well-publicised example – which led to reports and debates in parliament – was the tip of an iceberg. The iceberg melted slightly with increased NHS funding after the 1997 general election, but is as big as ever in the present financial climate. Not that funding is the only important issue.

In 1995 Sir Leslie Turnberg, then president of the RCP, wrote:

> 'There is widespread concern amongst physicians that increasing pressure to take on ever more work is impeding their ability to practise the high standards of medicine to which they aspire. Uncertainty, frustration and even despondency are beginning to threaten the sense of commitment to the NHS of many physicians in adult and paediatric practice. I constantly bring to the attention of the Department of Health and the NHS Executive the damage that is causing to the quality and standard of care we provide.'[2]

Why were the quality and standards of care falling in the 1990s? Were there not problems in the NHS before 1990? Yes, but nothing of the order or scale that followed the 1990 Act, and existing services were rarely compromised. In particular there were problems in mental health and community care because the closure of mental hospitals overwhelmed community care.[3] There is also no doubt that financial inefficiency was an issue throughout the NHS, but it could and should have been addressed more sensibly than in the 1990 Act.

The *Griffiths Report* of 1988, which led to the 1990 Act, was set up to address the failings in community care. Griffiths made many sensible recommendations to improve and coordinate community care, including a minister clearly responsible for community care. Instead, some care responsibilities were vaguely and variably added to the briefs of junior health ministers, a situation that persisted until the 2018 restructuring of the secretary of state's role.

The government ignored most of Griffiths' recommendations but seized upon his suggestion for greater financial efficiency in community care, including the separation of purchasers from providers, and applied it to the whole of the NHS. At the same time the Act unwisely further separated services in mental health and community care from physical health, adding to the relative neglect of psychological and social medicine.[4]

Despite the great efforts and achievements of frontline staff, the NHS/NHB has never adequately recovered from the profound changes implemented in the 1990 Act.

Indeed, further reorganisations, including the retrograde 2012 reforms, have further fragmented the service. Coordination, collaboration, communication and continuity of care are fundamental to the highest standards of medical practice and care, but all have been undermined and compromised since then.[5] Notwithstanding many centres of excellence, especially in acute physical care, scandals such as Mid-Staffs are only an extreme example of a more widespread decline in standards that have focused continuing attention on patient safety and staff morale.[6] The difficulties in maintaining high standards of care in the present dysfunctional NHS/NHB have been described yet again and most recently by Clarke[7] at junior hospital level and by Slater[8] at consultant level.

In the business world time is money. In the NHS/NHB time, which is a greatly valued commodity by patients, also costs money. With increasing knowledge, education, expectations and demands, the resource which is in shortest supply is indeed time. This has given rise to the understandable impression that so much hasty diagnosis and treatment is lacking in compassion and empathy, with widespread calls for a more 'holistic', 'personalised' or 'patient-centred' approach in the NHS.[9]

My understanding is that these values have long been central to the practice of medicine – and certainly I was so taught in medical school in the 1950s and witnessed widely prior to 1990 – but less so since then. These calls may be viewed as an indirect measure of a fall in standards. It seems that in the increasingly time- and cash-strapped NHS much has been squeezed or lost in the art of medicine, leading to so much concern about clinical standards now and over the last 25 years.

Clinical standards and financial efficiency

The 1990 Act is an important historical key to understanding and addressing many of the continuing challenges today which have flowed from it, aggravated of course by the increasing demands of an ageing population with complex (ie multiple) physical needs and ever more costly interventions. In my experience, the great majority of patients of all ages are complex because they have family, psychological and social needs that all too often are not addressed in a pressurised NHS. Nor can I see that the 1990 Act succeeded in introducing financial efficiency.

The introduction of an internal market, purchasers and providers in the NHS in 1990 has been a disaster for both the quality and efficiency of the NHS/NHB. It has been driven by political and economic ideology in defiance of common sense. It is obvious to the great majority of professionals that most patients cannot act as well-informed consumers looking for best quality and value of healthcare, all the more so as the supply of alternative services in the NHS is very limited indeed. Furthermore the market undermines many of the key drivers of both clinical quality and financial efficiency, ie collaboration, coordination, continuity of care and communication, while at the same time promoting fragmentation instead of integration of services and enormous bureaucratic and transactional costs.

According to Garattini and Padula[10] this and other 'pseudo-markets' have been a failure even in economic terms in both the NHS and in other European countries over the last 30 years.

The amount of money wasted in the present dysfunctional NHS is phenomenal. For example:

- the enormous managerial bureaucracy with its high and rapid turnover
- the frequent re-organisations, mergers, de-mergers, quangos, think tanks, systems analysts, consultancies, advisory bodies and reports
- the lack of staff planning leading to huge agency bills and expeditions abroad to recruit staff
- litigation (£1.63 billion for 2017–2018 and rising)
- worst of all, the staggering health costs arising from fragmentation and from the lack of continuity of care.

Some examples of the latter include:

- much waste of time in unnecessary or misguided clinical re-evaluation and or reinvestigation, sometimes leading to over-diagnosis and over-treatment[11]
- many unnecessary hospital readmissions due to premature and unwise discharges resulting from pressures and bottlenecks in the system, some of whom need never have been admitted in the first place with adequate community care
- 85,000 cancelled operations in 2018 – a rarity prior to 1990.

Each of these examples highlights an enforced but avoidable decline in professional standards.

I find it difficult to believe that the NHS/NHB is financially more efficient now than it was prior to 1990. I venture to suggest that the most financially efficient NHS is that associated with the highest quality and standards of care, incorporating:

- evidence-based care when available, which is often not the case, especially in the field of mental health and social care, but also in physical health
- reintegration of physical, psychological and social care
- coordinated continuity of care
- readily available good communication with a trusted and accountable designated professional, whether as an individual practitioner or the leader of a multidisciplinary team; all of which is in keeping with what patients actually want.

With evermore educated, informed (and sometimes ill-informed) patients in the internet age, the doctor–patient relationship has evolved from more paternalistic to more shared decision making, but either way a trusted relationship between patient and professional, doctor or otherwise, remains cardinal to the highest standards of medicine.[12]

But here is the dilemma. The present problems and challenges in the NHS were predictable and predicted at the time of the 1990 Act. For example, Sir Raymond Hoffenberg (RCP president 1983–1989) commented:

> 'Although I have expressed concern about the intrusion of cost-consciousness into clinical judgments, it cannot be ignored. No society (or country) is capable of providing the best available care to all its people all of the time. Cost-containment is inescapable. This means a debate about priorities and rationing of services.'[13]

With the steadily increasing demands on the NHS this debate is ever more urgent, but it seems ever more avoided. The word 'rationing' whether overt or covert is hardly ever mentioned. In view of the endless conflict and compromises between high service standards and financial efficiency it should be. Truog recently observed:

> 'Overcoming our inability to muster the political will and courage to acknowledge the necessity of rationing … is likely to be the greatest challenge in the evolving relationship between physicians and patients in the decades to come.'[12]

Solutions: principles of reform

Based on the above analysis I suggest the following principles of reform:

- Abolition of the internal market, purchasers and providers. This pseudo-market is a failure, which has led to the lowering of clinical standards and gross financial inefficiency, the very opposite of that intended. There is no place for competition in the NHS except for competition for the highest clinical standards between locally organised services. This is not an argument against the private sector, which can continue to evolve alongside and if practical supportive of the NHS, but the need for it would diminish if NHS standards were higher.
- The service needs of patients will vary locally for many geographical, economic and social reasons. Therefore services should be organised locally by those experienced in the provision and receipt of such services ie a better informed, more practical and humane bottom-up driver of standards rather than the present poorly informed and remote centralisation of services. There can be some debate about the size of 'local' but the former 'district' health services had some merit. Of course, there must be provision for more centralised centres of excellence of reasonable scale for complex high technology services for less common medical and surgical disorders. Such centres are also drivers of research and standards.
- The local integration of physical, mental and community services are fundamental to both clinical and financial efficiency. There is belatedly a greater political awareness of the need for this but it will not

be delivered without adequate staffing and funding.

- The concepts of collaboration and continuity of care should be reintroduced as a priority, both as a fundamental need of almost all patients but also to improve financial efficiency. Multidisciplinary care is both unavoidable and indeed often desirable both for care and for training, but the responsibility and accountability of individual or group leadership should be acknowledged and clear to the patient.
- Local professional providers of services, supported by their professional colleges and associations, should accept responsibility for driving and maintaining the highest clinical standards in place of the present more remote, conflicted, political, managerial and financial concepts or interests.
- A fundamental principle is that financial efficiency is associated with the highest clinical standards. To avoid the constant conflict between service needs and financial constraints, professionals should take responsibility for setting clinical standards locally and nationally within an agreed budget with the Department of Health. I am not an advocate of rationing but of aligning clinical standards with financial efficiency. Such an approach should reveal whether such high standards can be afforded by the country, or whether some degree of rationing is indeed needed. By focusing on high standards financial savings can at least be expected from efficient local integration of services, continuity of care, improved staff morale and greater patient safety.
- Although new technologies have their place, the current fashionable focus on them will not address the fundamental tensions between best service practice and best business practice, any more than the computer did in the 1990s.

Funding for the NHS is clearly the responsibility of the government, within its resources and priorities. Standards of physical, mental and community/social care are clearly the responsibility of professionals of all categories. The professionals, together with patients and public, can help the government to set health and care priorities but the professionals should concentrate on clinical service standards within a reintegrated service and avoid being drawn into political funding decisions for which they will be blamed, at least in part, when it comes to deficiencies and unavoidable covert rationing in the system. In a better future for the NHS both clinical and financial efficiency will be more readily aligned, with or without some overt rationing, in place of the present combination of lower clinical standards and financial inefficiency. ■

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Further references are available.

Correspondence e-mail: reynolds@buckles.u-net.com