Commentary

The NHS: A service under threat

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‘No more top-down re-organisation of the Health Service’. So said David Cameron in his pre-election statements. Then, as soon as the Tory Party was in office, along came Andrew Lansley with the biggest upheaval in the Service since Ken Clarke introduced the purchaser/provider split 20 years before.

Quite apart from proposals in the 2012 Health and Social Care Act, unwelcome though they have been, it was always going to be problematic to introduce radical change at the same time as stringent financial constraints were being enforced.

The ‘Nicholson Challenge’ of 2010 to make 4% ‘efficiency’ savings each year for 4 years, amounting to a total reduction of £20 billion, was never going to be straightforward. Couple that with the loss of Strategic Health Authorities and the introduction of new untried General Practitioner (GP)-led Clinical Commissioning Group (CCG.s), left the service behaving like a headless chicken as strategic oversight was lost regionally. The disappearance of managers made redundant by obsolete authorities and the re-employment of some in the new bodies led to a loss of continuity and collective memory. Now only a third of Chief Executives have been in post for more than a year and a half for over 2 years.1 Not a good way to introduce the changes that were needed to save money and improve the care of patients at the same time.

I reflect elsewhere on the difficulty that new Secretaries of State for Health have in resisting the temptation to introduce a new Health Bill whenever they get into office.2 Politicians rarely recognize that reform does not always require legislation. We have had no less than 11 new Health Acts during the 14 years I have been in the Lords. The resulting re and re-re-organization (what Ray Tallis describes as re-disorganization) has left many holding their heads in their hands at the varying degrees of mayhem that have been caused while doing little or nothing for the care of patients.

Advances in care have largely come from medical science and improved clinician activities while Government’s role in improving care when it did occur came, not from re-organization of the management, but from Labour’s dramatic increase in funding to bring it up to that of other Office for Economic Co-operation and Development (OECD) countries. Clinical staff increased by 130,000, waiting lists disappeared, patients began to be seen on the same day by their GP and patient satisfaction rose.3 Money did not go into a ‘black hole’ as some have tried to pretend.

But now we face a future with ever more stringent cuts and a projected underfunding of some £20 billion by 2021, a prospect that no one working in the service believes is remotely achievable.4,5 It is a prospect that is made even worse by the changes introduced in the 2012 legislation. The Act makes many unhelpful and distracting proposals but I will focus here on just one; the opening up of the service to competition from the private sector.

It is not as if competition did not exist before that. Indeed, the last Labour Government introduced the principle of private provision for some services. However the leap forward, or backward, that so devastated many was the introduction of a virtual obligation on all commissioners to go out to tender for any and every service unless it was clear that there was only one possible provider. It was this obligation, introduced in the unloved ‘Section 75’ following the 2012 Act, that clearly distinguished it from what went before and that made it so
unhealthy. Despite ministerial re-assurances and
despite efforts by Monitor to soften the blow,
the way in which this regulation has been inter-
preted in the field has seen a fearful and rigid
compliance.

And there are many examples of the problems
that have arisen. Hospital Trusts in Poole and
Bournemouth were keen to amalgamate their ser-
vices in a rational way to improve safety and effi-
ciency, avoid the £8.0 million deficit that was
looming and save £14 million per year. Despite
wide local support from clinicians, patients and
the public and after spending £6 million on legal
fees, the whole thing was blocked by the
Competition Commission on the grounds that it
was anticompetitive.

Or take the case of the CCGs in Blackpool that
had decided that it would be more efficient, and
better for patients with headaches not to have to
to refer them all to hospital only to be challenged by
a private provider for not sending them enough
cases. In trying to fight the case the cost to the
CCGs in legal fees and time was prohibitive and
certainly made other commissioners think twice
before embarking on a similar course of action.
A proposed unified cancer care pathway in Bristol
was put on hold for fear that it might come up
against lawyers keen to wave competition law in
their faces. And plans to integrate care for the elderly
between King’s College Hospital and the local coun-
cil is said to have been stopped by competition law-
ners. As David Nicholson, past chief executive of
the National Health Service (NHS), said to the
Health Select Committee, the NHS is getting
‘bogged down in a morass of competition law’, a
view that he has not been slow to re-iterate.7

So despite re-assurances from on high it is hardly
surprising that managers of commissioning bodies
play safe and go out to tender for every service,
whether it makes sense or not, rather than risk cut-
ting across one or more of the competition author-
ities. It is hardly surprising that 9 out of 10 chief
executives are said to make the cutting back of com-
petition rules their top priority.

But there are even greater reasons for fearing the
impact of these competition regulations and these
concern the effect on patient care. If the general
public were to be asked what were the biggest clin-
cial challenges facing the NHS most observers
would count very highly the burgeoning demand
for care of patients with multiple long-term illnesses,
largely in the elderly. And one of the key planks in
meeting that challenge is the need for a much
greater integration of care between hospital and
community services. The question you might then
ask is how does increased competition help that
aim? It would be a considerable struggle to find an
answer. Integration is entirely dependent on close
working co-operation between all service providers
while competition for each element of an integrated
care plan can only be divisive and counter-
productive.

It might also be asked what evidence is there that
competition and choice improves the efficiency or
standards of care. The results of academic studies
are equivocal at best. Some aspects may improve
others are made worse.8 Dixon and LeGrand9 sug-
ject that there is no evidence that the choice policy
has resulted in significant changes for the patient or
to patient pathways, while Zigante et al.9 concluded
after a careful review of the evidence that the ideol-
ogy of competition and choice is running ahead of
the evidence that it improves efficiency, equity
or quality. It is hard to escape the conclusion of
Light when he argued that promotion of competi-
tion is guided by political and ideological consider-
ations and is not supported by any scientific
evidence.10

The 2012 act has clearly been an unwelcome
intervention. At a time when the service is facing
unprecedented financial constraints and an uncer-
tain future, the struggle to cope with both the
introduction of a dramatic re-organization of man-
agement and of stringent competition regulations is
a considerable distraction.

The £20 billion savings in the last 4 years has
been largely achieved by a combination of short-
term measures such as wage freezes, early retire-
ments and redundancies that are not sustainable in
the long run. Already 40% of hospital trusts are said
to be in financial difficulties. The year 2015 is
viewed as a ‘crunch’ year and the shortfall of a fur-
ther £30 billion projected by 2021 will see the share
of GDP spent on health care fall from around the
current 6% to 7% compared with that of 8.4% in
2010.11 This will be the lowest proportion of GDP
spent on health care of any OECD country. It is a
reduction that cannot be withstood simply by ratio-
nalizing and reducing hospital care and moving
much of it into the community while trying at the
same time to raise the standards of care that
Governments speak so glibly about. All of these
changes may be essential but it is inevitable that
more money will need to be found and in a country
said to be the fourth wealthiest in the world and with
more billionaires per square inch than anywhere
else it should not be an impossibility.

It all depends too on any future secretary of state
curbing his or her inclination to introduce yet an-
other disastrous top-down re-organization.

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References


