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Perspective

Making and breaking a health service

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Abstract: The creation of the National Health Service (NHS) marked a radical break with the past, making health care universally available on the basis of need rather than means. The NHS was conceived during wartime emergency and has had to survive further regular crises to reach its 70th year, but it now faces challenges that are unprecedented in scale and there are doubts about its ability to continue in its present form. Resources have not increased with need, and the NHS can no longer function as a comprehensive service during periods of peak demand. Policymakers look for solutions in service rearrangements, new technologies, quality improvement initiatives and alternative funding arrangements; meanwhile, chronic lack of capacity is taking a predictable toll on patient care and staff morale. The NHS has become a formidably resilient institution, but securing its future may take as great a collective effort as the one that created it.

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Crisis?

The National Health Service (NHS) enters its 70th year teetering, once again, on the edge of the abyss. Seven years of fasting following several years of feast have predictably reduced the system's resilience to shocks – even expected ones (Maynard and Street, 2006) – and a rising winter tide of norovirus and influenza has triggered a wave of black alerts (Kershaw, 2018). Patients have been turned away, doctors have burned out and nurses have fled (Siddique, 2017). The comforting tragedy, Klein reminds us, is that this pantomime plays out every year, and the denouement remains the same: spring arrives, waiting rooms empty and the service revives. But for those at the coal face, there is little light visible at the end of a tunnel that looks longer and darker than any traversed before. Present crises loom largest, and there are no guarantees that the NHS's ongoing travails will

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have the same happy(ish) ending as those of the past. Today's patients and staff can also broadcast their anguish via social media, an outlet that previous generations lacked, lending an urgency and volume to current tribulations, amplified by a traditional media alert for omens of imminent catastrophe. In reality, the NHS is unlikely, in the absence of an overwhelming pandemic, to collapse in a heap. More plausibly, localised service failures – real or apparent – will provide an excuse for their piecemeal replacement by external providers, and the NHS corpus will be slowly eaten away. However, the appetite of private providers to come to the trough after Circle's Cambridgeshire misadventures (Public Accounts, 2015), and the willingness of commissioners to feed them after Carillion's collapse (Conway and Mor, 2018), may not be as great as defenders of socialised medicine fear.[1] Outsourcing will continue, but not to the extent that nothing is provided from within.

Responses

Notwithstanding any perceptual distortions, there are objective signs of chronic and mounting distress across the NHS, with the underlying problem of ever more patients being admitted into ever fewer beds (Ewbank *et al.*, 2017). One way of rebalancing this increasingly lopsided equation is to stem the rising tide of admissions, by creating a healthier, better informed, more responsible – and ultimately less demanding – population. Unfortunately, need is not easily suppressed. Illness and ill fortune capture even the most health conscientious, and better informed populations may be no less likely to seek care – often the reverse is true. Whilst the information age has placed the collective wisdom of the medical academy – and a range of alternative sources – at the fingertips of everyone with internet access, it is yet to confer the navigational skills to make sense of it all (the success of the Royal College of GP's internet-endorsing 'three before GP' campaign[2] will depend heavily on Dr Google's algorithms – and its lack of reassurance and compassion). The wait for new gadgetry that cajoles users along the road to wellness to fulfil its early promise continues, and the attendant explosion in personalised data may be about to tap vast new reservoirs of demand

1 Circle Health is a limited liability company that operates independent hospitals and treatment centres under contract to the NHS. In 2011, Circle was awarded a 10-year contract to run Hinchingbrooke Hospital in Cambridgeshire, but withdrew in 2015 after an inspection by the Care Quality Commission rated care at the hospital as inadequate.

Carillion plc was a major construction and facilities management company that provided building, maintenance and cleaning services to the NHS. It was forced into compulsory liquidation in January 2018, putting the provision of key services in several hospitals at risk.

2 The Royal College of General Practitioners (RCGP) launched the '3 before GP' campaign in December 2017 in an attempt to relieve pressure on general practices during the winter season. Patients were encouraged to explore three alternative options before contacting their general practice: self-care; consulting NHS Choices or 'similar reputable websites'; or seeking advice via a pharmacist (RCGP, 2017).

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for health services to deal with. Other innovations – in technologies, services, processes and systems – may reduce some of the inward flow of patients, and may even do so cost-effectively, but age and deprivation create the strongest currents of need, and even the most ingenious public health interventions are helpless against them.

On the supply side, the obvious trick of increasing capacity has not found favour with a government caught in the lull between two financial storms (the Great Recession and whatever turmoil accompanies Brexit) and unwilling to untighten the funding screw. Providers are therefore obliged to become more creative. For example, hospitals with no prospect of receiving new beds must clear existing ones more quickly. The perennial hope is that integrating the health and social care systems will allow patients whose acute needs have been met to be returned swiftly to the community. The government plans to bring these two crisis-prone and underfunded services together in England by 2020, but this ambitious timetable is already slipping [Northern Ireland has been trying to blend the oil of health with the water of social care for over 40 years (O'Neill *et al.*, 2012)]. Even if integration can be achieved, hospital bottlenecks may not be cleared; the flagship integrative programme – the Better Care Fund – has achieved a degree of closer cooperation between health and social care without making any discernible dent on admissions or transfer delays (Comptroller and Auditor General, 2017).

Money

There is a growing realisation that however efficient the service becomes, whatever new level of personal responsibility the population attains, and however challenging the economic context, more resources will be required if the NHS is to live up to its founding principles of comprehensiveness and universality. This prospect has again provoked demands for a 'conversation' about where the NHS's funding comes from, usually issued by those hoping to lower their contributions towards it, or to earn more from it. Their argument is that adding additional funding streams, including upfront payments, will encourage people to become more responsible in their health behaviour and more discerning consumers of health care, and will put a stop to the all-you-can-eat NHS buffet that the poorer and sicker enjoy at the expense of the richer and healthier. This boils down to a desire to turn the clock back 70 years – punishing the sick for their misfortune by recasting it as fecklessness. Whilst it is true that individuals will have to make a behavioural contribution towards restraining the NHS's spiralling costs if it is to survive (Wanless, 2002), any attempt to educate, fine or nudge people towards good health must take account of the cognitive and material constraints imposed by the social environment (Mani *et al.*, 2013). Finding the balancing point between personal and societal responsibility for health is horribly difficult, not least because no one can agree on where it is. Imposing financial hurdles may be

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seen as a necessary corrective in the direction of personal responsibility, but this approach assumes a degree of rational economic behaviour frequently absent from health decisions – fear is extremely effective at bypassing critical faculties. Making everyone pay at the door is unlikely to trigger a mass re-examination of needs and preferences, and could lead to more, not less, demanding behaviour. In many cases a financial hurdle will only delay necessary and urgent care with tragic – and in the final analysis more costly – consequences (Brook *et al.*, 2006). Ultimately, the multiple funding stream argument is a red herring; all the NHS's cash is drawn from one source – all of us. Funnelling it through more pipes would make it harder to follow where the money goes and increase the opportunities for leakage and diversion (Reinhardt, 2011).

However the money is raised, the best guess is that by 2022 the NHS will need an additional £25 billion per year just to stand still (Nuffield Trust *et al.*, 2017), and there are signs that this penny has finally dropped for some cabinet members (*BBC News Online*, 2018). Even more will be required if the NHS is to entertain higher ambitions than clinging on by its fingernails every winter. Providing the best care – for everyone, in every season – would be a more laudable aim, and closer to the one Bevan originally intended. But in addition to resources, the pursuit of quality needs a more considered approach than has been taken in the past. Klein describes the NHS's development from a service that measured next to nothing to one that tries to measure everything, but the exponential increase in inspection and bureaucracy may, at great cost, be concealing rather than revealing suboptimal care (the jury is still out on whether the Care Quality Commission's inspection programme results in better care, and medical revalidation has generated an immense administrative burden whilst still effectively allowing doctors to mark their own homework).

If funding is increased, it would need to be dripped rather than poured in and diverted to the right places. Sudden influxes tend to be soaked up by the professions and to create a demand for unsustainable or ineffective services (Maynard and Sheldon, 2002). The NHS, through NICE, now has a mechanism for judging cost-effectiveness, but these judgements focus on average effects and lack an explicit equity perspective (Asaria *et al.*, 2016). Consequently, well-intentioned interventions can increase health inequalities due to their differential impacts across social groups, which is a serious shortcoming for an institution founded on equitable principles. Introducing comprehensive equity impact analysis,[3] and funding formulae that explicitly address deprivation, could finally achieve the territorial justice that Klein suggests is within grasp. NICE's technical analyses will also have to be accompanied by difficult and long neglected public

3 As the author is involved in exactly this kind of research, the reader should treat this assertion with the appropriate degree of scepticism.

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conversations on urgent ethical issues, for example end-of-life care and voluntary euthanasia.

People

It is not necessary to be committed to the NHS's ideals in order to work for it, but many do and it certainly helps. But righteousness should not be the reason why people come to work and policymakers should not rely on it. A pleasant and supportive environment should be a minimum expectation, with sufficient resources – including adequate time – to deal with patients appropriately. When these expectations are not met, not only are there adverse consequences for individual staff and their patients, but the whole fabric of the NHS is unpicked, as collegiality breaks down into factionalism and compassion sours into indifference and cruelty (Francis, 2014). Of all the NHS's challenges in the coming years – technical, organisational and professional – maintaining kindness towards both staff and patients is perhaps the greatest. But this challenge, as with most facing the NHS, is not entirely new – certainly not to Rudolf Klein, who has chronicled every one of the NHS's short and long-term cycles. Not only does he recognise the patterns, he understands better than anyone the forces behind them. If he says the NHS will survive, we should probably cross our fingers, put our shoulders to the wheel, and believe him.

References

Asaria, M., S. Griffin and R. Cookson (2016), 'Distributional cost-effectiveness analysis: a tutorial', *Medical Decision Making*, **36**: 8–19.

BBC News Online (2018), 'Boris Johnson to push for more cash for NHS', *BBC News Online*, 23 January, http://www.bbc.co.uk/news/uk-politics-42783247 [23 January 2018].

Brook, R., E. Keeler, K. Lohr, J. Newhouse, J. Ware, W. Rogers, A. Ross Davies, C. Sherbourne, G. Goldberg, P. Camp, C. Kamberg, A. Leibowitz, J. Keesey and D. Reboussin (2006), 'The health insurance experiment'. RAND Research Brief, https://www.rand.org/pubs/research_briefs/RB9174.html [14 November 2017].

Comptroller and Auditor General (2017), *Health and Social Care Integration*, London: National Audit Office.

Conway, L. and F. Mor (2018), 'The Collapse of Carillion', House of Commons Briefing Paper No. 08206, 18 January, http://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-8206#fullreport [20 January 2018].

Ewbank, L., J. Thompson and H. McKenna (2017), *NHS Hospital Bed Numbers: Past, Present, Future*, London: The King's Fund, https://www.kingsfund.org.uk/publications/nhs-hospital-bed-numbers [12 January 2018].

Francis, R. (2014), 'Culture, compassion and clinical neglect – probity in the NHS after Mid Staffordshire', *Journal of Medical Ethics*, **2013**: 101462.

Kershaw, M. (2018), *Black Alerts: For Emergencies Only?*, London: The King's Fund. https://www.kingsfund.org.uk/blog/2018/01/black-alerts-emergencies-only [12 January 2018].

Mani, A., S. Mullainathan, E. Shafir and J. Zhao (2013), 'Poverty impedes cognitive function', *Science*, **341**: 976–980.

https://doi.org/10.1017/S1744133118000087 Published online by Cambridge University Press

Maynard, A. and T. Sheldon (2002), 'Funding for the National Health Service', *The Lancet*, **360**: 576.

Maynard, A. and A. Street (2006), 'Seven years of feast, seven years of famine: boom to bust in the NHS', *British Medical Journal*, **332**: 906–908.

Nuffield Trust, Health Foundation and The King's Fund (2017), 'The Autumn Budget: Joint Statement on Health and Social Care', https://www.kingsfund.org.uk/publications/autumn-budget-2017 [2 January 2018].

O'Neill, C., P. McGregor and S. Merkur (2012), 'United Kingdom (Northern Ireland): health system review', *Health Systems in Transition*, **14**(10): 1–91.

Public Accounts (2015), 'Public Accounts – Forty Sixth Report. An Update on Hinchingbrooke Health Care NHS Trust', https://publications.parliament.uk/pa/cm201415/cmselect/cmpubacc/971/97102.htm [20 January 2018].

Reinhardt, U. (2011), 'The many different prices paid to providers and the flawed theory of cost shifting: is it time for a more rational all-payer system?', *Health Affairs*, **30**: 2125–2133.

Royal College of General Practitioners (RCGP) (2017), '"3 before GP": New RCGP Mantra to Help Combat Winter Pressures in general Practice', http://www.rcgp.org.uk/news/2017/december/3-before-gp-new-rcgp-mantra-to-help-combat-winter-pressures-in-general-practice.aspx [12 January 2018].

Siddique, H. (2017), '"Haemorrhaging nurses": one in 10 quit NHS England each year', *The Guardian*, 17 January 2018, https://www.theguardian.com/society/2018/jan/17/nhs-england-hospital-staffing-one-in-10-nurses-quit-each-year [20 January 2018].

Wanless, D. (2002), *Securing Our Future Health: Taking a Long Term View. A Final Report*, London: HM Treasury.

https://doi.org/10.1017/S1744133118000087 Published online by Cambridge University Press