

Accidents will happen? Lessons from the Covid-19 pandemic

The Foundational Economy Collective

Underfunding and a decade of top-down reorganisations have made the NHS dangerously fragile. We need not only an increase in NHS funding, but also a new approach, replacing the top-down control paradigm with a new, more consultative and iterative, culture.

Expect many inquiries into what went wrong in the early stages of the Covid-19 pandemic. Some will ‘name the guilty men’ and highlight policy-makers who indeed made major mistakes, including the delay in imposing lockdown. Others will present ‘arrow indicates defective part’ explanations and blame agencies like NHS Supply Chain with its limited reach into the PPE supply chain, or Public Health England, for its anaemic inability to upscale Covid-19 testing. But what were the deeper reasons for such failures? And why did specific failures proliferate into unanticipated and uncontrolled large-scale breakdowns?

The reasons for these proliferating failures are analysed in the Foundational Economy Collective’s public interest report, *When Systems Fail*.¹ We argue that what happened in the early stages of the pandemic was (in the language of science and technology studies) a *normal accident*, an accident waiting to happen because fragility had been built into the system. The acute hospital system had no buffers because it was running with no spare capacity, and then it cleared beds by discharging untested elderly patients into care homes and freed up staff by suspending other treatments. The public laboratory system lacked back-up because Public Health England (PHE) was over-reliant on its own limited test capacity and could only slowly bring other laboratories online.

The UK acute hospital sector is run as a low-stock, high-flow system. This means that it is inherently vulnerable to disruption by a surge in demand. Other North European countries have more staff and beds in relation to population, and acute bed occupancy rates of 60-70 per cent as against 90 per cent-plus in the UK. With their limited resources, UK hospitals are unusually dependent on the continuous and rapid flow of patients. This is also true for critical care: in January 2020 there were just 700 empty intensive care beds for an English population of 56 million.

As for the public health laboratories, successive NHS reorganisations after 1991 have unintentionally undermined the existing distributed laboratory system and its potential surge capacity to handle large-scale testing. Fifty public health area laboratories vanished or were assimilated into hospitals, and hospital laboratories became cost or profit centres within hospital trusts in NHS reorganisations that privileged financialised relations between primary care purchasers and hospital providers. As a result, Public Health England lacked the networks needed to scale up testing, while concentrating primarily on research excellence at its central laboratory.

This double fragility was unintentionally caused by a combination of long-term funding shortages and a process that political scientists call hyper-innovation. The damaging effects of austerity in the 2010s were compounded by the continuing organisational churn that had been imposed on the NHS and public health over the previous two decades. This hollowed out these services and eroded their capacity to respond to emergencies in adaptable and resilient ways. As a consequence, when government needed anything quickly and in volume – field hospitals, PPE, laboratory testing, tracing – there was no alternative to ‘distress outsourcing’, with its predictably unsatisfactory results.

Recovering from this condition of chronic incapacity will be difficult. Increasing physical resources through extra funding is a basic precondition of increased robustness. At the same time, more hospital beds, PCR machines and staff will not deal with the mis-organisation. And the financial and organisational problems are both, separately, hard to solve.

Adding buffers for robustness will be expensive: a 10 per cent increase in the number of NHS acute beds would incur an operating cost of £2.9 billion – more than half the current annual NHS funding increase agreed in 2018. If the long-run target is to increase UK spending on health and care to French and German levels, this will require an extra 1.5 per cent of GDP and a 5.4 per cent increase in UK tax revenues to raise an additional £33 billion each year. This kind of extra funding almost certainly implies comprehensive reform of the UK tax system, since after the pandemic there will be many other just demands on spending, and an extra burden of debt to service.

NHS mis-organisation will be difficult to address directly. This is because it is an unintended consequence of repeated re-organisation. Indeed, we argue that the underlying problem in the UK health system is a top-down *control paradigm*, which

has sought to turn NHS managers into agents of central policy in order to control clinicians. Distinguishing ‘efficiency’ from ‘effectiveness’, we suggest that the latter – and the resilience that goes with it – is only possible if we create and foster appropriate forms of practice on the ground. To think about this we suggest that the NHS might learn by exploring the ‘logic’ of clinical care for chronic conditions. We show that this works consultatively and iteratively as it manages different priorities and concerns in the search for a good quality of life.

But what might such a *careful practice of policy* mean in specific cases and places? In our report we make some suggestions which overlap with those of Iliffe and Bourne and the New Era thinkers in this issue of *Renewal*. Thus, we agree that public and political debate about the future of the NHS needs to be broadened. This has become fixed on the issue of funding levels and the role of private providers of public health services. Both are important, but it is time to register the underlying problem presented by the control paradigm, and the collateral damage that this has produced, through its pursuit of an efficient health care system and its failure to recognise that this generates vulnerability and the potential for ‘normal accidents’.

In our view, the NHS hospital and laboratory systems may be likened to an elderly patient suffering from chronic conditions with comorbidities that are partly the result of ill-judged acute interventions. What is needed is a new kind of policy-making process involving decentralised experiment, delegation of responsibility, loosening of control and the creation of new fora for public deliberation. If this seems unsatisfactory, readers should remember that the transformative NHS of 1947 was built on the success of the experiments of the 1930s in comprehensive whole-population health-care in the two small Welsh towns of Llanelli and Tredegar. It is time to revive this tradition of local initiative as a way of reanimating a mis-organised NHS.

The Foundational Economy Collective is made up of academics and practitioners from many European countries, committed to challenging mainstream ideas about what economic policy should be, and focusing on the foundational economy – including health, care, education, housing, utilities and food supply – the basic goods and services which drive welfare and form the basis of citizenship.

The authors of the report, *When Systems Fail: UK acute hospitals and public health after Covid-19*, are **Julie Froud, Colin Haslam, Sukhdev Johal, John Law and Karel Williams**.

Notes

1. Foundational Economy Collective, *When Systems Fail: UK acute hospitals and public health after Covid-19*, 2020: <https://foundationaleconomycom.files.wordpress.com/2020/06/when-systems-fail-uk-acute-hospitals-and-public-health-after-covid-19.pdf>.