The English NHS: from market failure to trust, professionalism and democracy

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The third instalment of our Soundings Futures series analyses the problems in the NHS and offers some solutions

In the summer of 2016 the fate of the NHS in England hung in the balance. The funding squeeze imposed by George Osborne had reached a point where it was clear that services were not being made more efficient - as government rhetoric persisted in maintaining - but were being cut. Waiting times for treatment for even urgent conditions were rising steadily, while draconian new spending cuts were being enforced on hospitals with budget deficits that everyone except the Secretary of State, the regulator and the Treasury recognised were due to inexorably growing demand.[1]

There was no obvious way out of the crisis except by restoring an adequate level of funding, something that a reformed tax system and moderate economic growth could well support. But the post-referendum economic outlook made this an unpalatable prospect for Osborne's successor, Philip Hammond. If per capita funding falls any further the NHS could be reduced to a residual, low-quality free service, leaving those who could afford it to take out private medical

insurance. But not only would this be intensely unpopular, not least with older Conservative voters; there are also no private health facilities capable of meeting a major increase in demand for private care. To compound the government's problem, the Health and Social Care Act of 2012, which was supposed to complete the project of making the NHS more efficient by fragmenting it into a system of independent trusts and subjecting them to market competition, has proved a comprehensive failure, while adding to its cost. The Chief Executive of the NHS, Simon Stevens, who took over in early 2014, set himself to try to solve the problem by recreating a system of central management that strongly resembles that of the original NHS, while leaving the 2012 Act unchanged - but this approach has a limited life-span given the legal constraints, not to mention the questionable politics, that it involves.

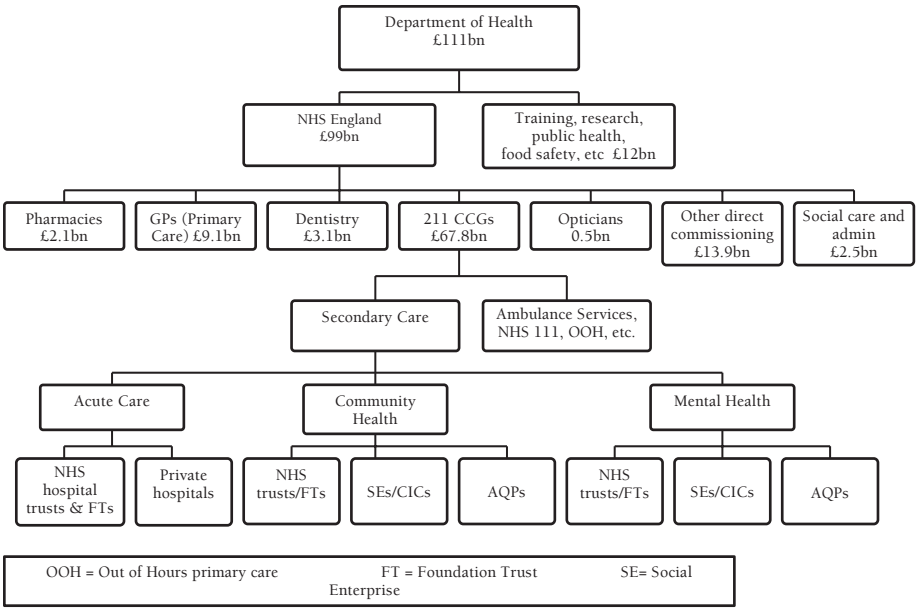
Faced with the bankruptcy of the market model, its proponents assert that the NHS as originally conceived is out of date and 'unaffordable', implying that it can only survive if some radical new system of service provision is adopted, which it is up to supporters of a free and comprehensive NHS to propose. But this is spin. The route to a revived and successful NHS does not lie in 'new models of care', although innovative models always deserve consideration, but in taking a limited number of measures to restore the service's essential strengths: scrapping the dead weight of the 2012 Act; terminating for-profit provision of clinical services; trusting health professionals instead of treating them as self-interested slackers; replacing the apparatus of audits and penalties with a pro-active system of democratic accountability in both national and local health policy and decision-making; and giving public health a prominence in all spheres of policy that it has never previously enjoyed.

The failed market project

Over the last thirty years relentless ideological pressure and health industry lobbying have induced successive governments to push towards making health care into a commodity: they have reorganised the main providers of NHS secondary care - hospitals, ambulance services, mental health services - into a system of nominally independent businesses ('trusts') run on business lines, to the point where Andrew Lansley, as secretary of state for health in the Coalition government, could finally

inaugurate a proto-market in health care. The Health and Social Care Act 2012 allowed private companies to compete with NHS hospital trusts, ambulance trusts and mental health trusts to provide NHS-funded services, and required the commissioners of care - Clinical Commissioning Groups, or CCGs - to invite them to bid to do so (see Figure 1). The state, however, remained the 'single payer' on behalf of patients - a crucial step short of a full market in which patients, or their insurers, pay for whatever care they can afford.

Figure 1. The NHS under the Health and Social Care Act 2012 (2014/15 budget data)



The 2012 Act was seen by some of its main protagonists as a transitional stage towards a full market, but it was justified primarily in terms of giving GPs, who were said to know what their patients need, power to choose services and providers on their behalf, and as a more effective means of containing costs. Cost-containment had been a major concern of the Treasury from the day the NHS began, but with the adoption of the nostrums of the 'New Public Management' - the application of neoliberal doctrines to public administration - the Department of Health came to believe that the best way to contain costs was to replace government control by market forces.

But going even this far towards creating a healthcare market was politically fraught, because the NHS is so deeply embedded in everyone's life. Some 660,000 people use NHS services every day; NHS staff account for almost 5 per cent of the active workforce; and even the eleven per cent of the population who have some private medical insurance rely on the NHS for anything really serious, because very few full-service private hospitals exist. Resistance to the introduction of for-profit provision remains strong, including among doctors. And the marketisers failed to understand that health services are radically unlike like most other public services. Good health care - even merely safe health care - depends implicitly on highly-trained staff in a wide range of disciplines, working with patients in complex patterns of collaboration and with a strong ethos of professional commitment. In this respect the NHS is more like the armed forces, which the marketisers would never dream of fragmenting in the way that commodification requires, than like the postal service or the railways.

In practice health care in England has not become a market, for two main reasons. First, while NHS hospitals, mental health clinics and ambulance services may have been converted into trusts and made to simulate private companies, they can't be allowed to become bankrupt and close without an unacceptable local breakdown in health care. Furthermore, the planned closure of almost any major hospital service means a politically costly fight with community activists.[2] So the ultimate driver of efficiency in markets, the replacement of less efficient by more efficient producers, doesn't operate.

Second, neither NHS trusts nor private healthcare companies can become ever more efficient, and so more profitable, by substituting capital for labour, as occurs in other fields. Drugs, and some medical technology, such as insulin pens and heart monitors, can partly substitute for routine clinical work; but most new technology needs new skills to operate it. Over time the proportion of scientific and technical therapeutic staff in the NHS workforce has risen, not fallen; and hands-on work remains critical for diagnosis and most treatments. This means that it is difficult to make a profit from providing health care except by having a monopoly of some kind (in which case there is no incentive to improve efficiency); or by, in effect, cheating - for example by ordering unnecessary tests or even doing unnecessary operations (as happens in fee-for-service systems); concealing unsafe staffing levels (as Serco did in its out-of-hours GP service in Cornwall); 'up-coding' (recording patients as

higher-risk than they really are, and charging accordingly); or outright false billing (which occurs on a very large scale in the US).[3] While some private companies have secured local monopolies - such as out-of-hours GP services (20 per cent of the total by value); clinical services such as audiology and physiotherapy (30 per cent); and diagnostics - these are services that can be provided in non-hospital settings and require limited capital to set up. But so long as the public expect equal and free access to good healthcare, and the government remains committed to paying for it and closely watches its spending, it is not possible to make serious money from providing secondary acute care.

It might have looked possible during the years from 2000 to 2008, when the Blair government was injecting dramatic increases of funding into the NHS. But austerity policies since the financial crash have meant flat real-terms health budgets from 2010 onwards, at a time when the UK population has been growing at close to half a million a year, and presenting greater numbers of age-related conditions for treatment. This has put even more pressure on CCGs to award contracts to the lowest bidder, but the low bids they are now looking for are often too low to be attractive to private bidders. When in 2013 the financial regulator, Monitor (now called NHS Improvement), relaxed its pressure on CCGs to put all contracts out to tender, and allowed them instead to negotiate new contracts with existing (mainly NHS) providers, there was relatively little protest from the private sector. As Roy Lilley, a former NHS Trust chair, put it in his widely-read blog, 'there is not enough money to make a margin'.

A particularly instructive moment was the failure of the private equity-controlled company Circle Health to make money from taking over the management of an NHS hospital in Hinchingbrooke in Cambridgeshire. Outside London there are hardly any full-service private hospitals, so taking over the management of existing NHS hospitals looked like a promising way of avoiding the daunting costs for a private company of building and staffing new hospitals in order to compete in the acute care market. But under Circle's management, between 2012 and 2015, the hospital's deficit doubled, and in the effort to cut costs Circle's management reduced the quality of care to the point where the Care Quality Commission found the hospital's safety performance so 'inadequate' that it recommended putting it into 'special measures'. Circle walked away from the contract after just three years, having lost £5 million of its own money and leaving the NHS to cover an additional deficit of £9 million.

The failure of the 2012 Act has been a major embarrassment to the Conservative Party, which used up considerable political credit in pushing it through parliament in direct breach of its 2010 election promises. The Act's architect, Andrew Lansley, was dispatched to the Lords, but there still remains an acute problem of how to maintain NHS services in face of fast-growing demand, especially since the reorganisation - which had itself cost £3 billion to implement - raised the NHS's operating costs without providing any mechanism to improve efficiency.[4]

The Five Year Forward View

The proposed solution was a plan put forward in 2014 by the newly-appointed chief executive of NHS England, Simon Stevens, in his *Five Year Forward View* (FYFV), which was agreed by the government.[5] The essence of the plan was that in return for some limited additional annual funding the NHS would transform the way it worked, both cutting costs and reducing 'demand'.

Three features of the FYFV and its implementation need to be emphasised. The first is the scale of the cuts that it implies. In 2012 it was estimated that rapid population growth and growing healthcare needs (always described, in the market-driven language of contemporary health policy, as growing 'demand'), plus the rising cost of energy and other inputs, would mean that by 2021-22, simply to maintain services at their existing level and quality, the NHS would need about £30 billion per annum more than the government was planning to spend on it.[6] Under the FYFV plan additional funds of £8 billion would be made available by 2021-22, leaving the NHS to find savings of £22 billion - almost 20 per cent of the total health budget. Of this, NHS providers (mainly hospitals) are expected to find £8.6 billion by 'releasing efficiencies' (cutting costs), and 'local health economies' are expected to save 4.6 billion by 'moderating the level of activity growth through care redesign, interventions such as Right Care and Self Care', and other 'efficiencies'.[7] But no one thinks hospitals can improve efficiency to anything like that extent, and, as the Chief Executive of NHS Providers has plainly said, 'there is little evidence that moving to new care models will release rapid or sufficient savings'.[8] Whatever relief the plans adopted may give to the Treasury, they imply a loss of coverage, staffing, access and quality for patients.[9]

The second remarkable feature of the NHS planning process inaugurated by the

FYFV is its extraordinary, extra-legal and absolutely centralised nature. The changes outlined in the document are now being implemented throughout England by the local 'health systems' of 44 areas - called 'footprints' - each covering an average of 1.2 million people and typically comprising five CCGs, one or more NHS hospital trusts, and several local councils. All 44 'systems' were required to produce - initially by the end of June 2016 - five-year Sustainability and Transformation Plans (STPs), which must include (a) acceptance by all providers within the 'footprint' of spending limits laid down by the Treasury; and (b) detailed plans for achieving the transformative ways of delivering health care outlined in the FYFV. Plans which fail to meet these requirements will render the whole footprint area ineligible to receive a share of the additional money in the Sustainability and Transformation Fund - the annual tranche of the £8 billion additional funding promised by the government in return for the adoption of the FYFV.

There is no legislation providing for any of this, whether for the coordination of the various bodies, including local councils, in each footprint, or for the appointment of people to lead the planning process, or for settling disagreements about the plans.[10] A leader of the planning process - usually the chief executive of a CCG - has been designated for each footprint by NHS England, which has also declared that any two CCG chief executives can overrule a third one if he or she dissents from what all the other CCGs in a 'footprint' have agreed. When one CCG board member in London pointed out that under the 2012 Act his CCG was responsible for the health care of the patients registered with its member practices, he was told that, although this was true, if it chose not to go with the plans agreed by the other CCGs, the area would get none of the additional money allocated to the transformation process.[11]

This kind of informal policy-making process, with the law saying one thing but practice being something else, is familiar in many countries of the global south. Being untransparent and unaccountable, it tends to produce bad policy and to fall prey to conflicts of interest, special deals, nepotism, cronyism and corruption. But the government does not want to acknowledge the fact that the Health and Social Care Act has been an expensive disaster - although Conservative MPs often say so privately.[12] It is an implicit part of the deal between Simon Stevens and the government that he has regularly declared that there is 'no appetite' for changing the structures created by the Act. So an Act that calls for the NHS to be made efficient

through market competition remains in force, while in reality the NHS is being re-reorganised under the most centralised control it has ever experienced. Advocates of the market were fond of describing the original NHS as a 'Stalinoid' system of 'command and control', although it had an organisational structure laid down by parliament, a secretary of state answerable to parliament for its operation, and, from 1974, a system of Community Health Councils which added a significant element of local accountability. The current situation, by contrast, is a system of command and control with none of these constraints: it is not even accountable to parliament any more, since the Secretary of State is no longer legally responsible for 'providing' the health service, but only for 'promoting' it.

The government is careful to say that all the changes CCGs are signing up to must be reflected in CCG Board minutes and embodied in contracts, just as if they had been freely made by the CCGs, even though in effect they are being made by NHS England and its regional teams. This means that large sums of public money are being spent, and major changes are being made to the services the public will receive, with no genuine accountability. The NHS currently operates in a surreal world where little is what it officially seems. The 2012 Act has become a zombie law: the fragmented structures it created are openly 'worked around', as CCG insiders put it, as they struggle to meet the demands of NHS England and earn their share of the transformation money that is on the table.[13]

And this leads to the third striking aspect of the FYFV: its comprehensive rejection of the aims and principles of the 2012 Act. Competition, which the Act was designed to promote, is not mentioned once in the FYFV. The 'purchaser-provider split', with CCGs choosing between competing providers, which was to be the key to competition, is effectively suspended: what services are to be provided, by whom and in what ways and at what cost, is now being decided by NHS England, while CCGs merely go through the motions. Instead the emphasis is everywhere on 'integration' - between primary and secondary care, between health care and social care, between hospital services and community health services, and 'across patient pathways' (i.e. between different specialties). Some steps towards integration that have been floated in the extra-legal free-for-all, such as CCGs sharing powers with hospital trusts, have been found to be impossible without a change in the law - a 'workaround' too far. Simon Stevens, however, advocates the formation of 'combined authorities' and a 'pooling of sovereignty' between CCGs, providers and

local councils, without changing the law.[14] What is emerging from this officially-encouraged process of 'working around' the 2012 Act, in order to reintegrate what the Act has broken up, are thus, not surprisingly, embryonic informal structures that increasingly look like ghostly revenants of the Regional and District Health Authorities of the once unified NHS.

But the Act's living dead still have their legal duties to perform. Despite the A&E crisis and the fast-growing waiting times reported weekly in the media, the financial regulator (NHS Improvement) tells the trusts with the biggest deficits to 'reduce their headcounts' (i.e. cut staff), while also telling them to reduce their spending on agency staff (which they need for safe nursing cover when short-staffed);[15] and Mr Hunt, who, ever since the Mid Staffordshire disaster, where staff cuts led to hundreds of deaths, has been a loud champion of patient safety, now tells hospital trusts that not balancing their books is 'not an option', and that trust directors who fail to comply face suspension.[16] He also insists that seven-day hospital working must be adopted and imposes a contract on the junior doctors for the purpose, even though it is recognised by all concerned that staffing hospitals fully at weekends is impossible without either more money, or reducing weekday services. As for the regulator of quality, the Care Quality Commission, it writes a joint letter with NHS Improvement telling trusts that 'quality and financial objectives cannot trump one another': they must deliver 'the right quality outcomes within the resources available'.[17] In short official buck-passing has become endemic - as one would expect in a situation of underfunding combined with legal make-believe.

Abolishing the legacy of the failed market project

Sooner or later arbitrary management and irresponsible government - refusing to face the reality that growing need cannot be safely met without growing funding - will come to an end. At that point it will be important to register the comprehensive failure of the Health and Social Care Act, and to be ready with measures to replace it with a rationally ordered public service, based on principles the public have consistently supported. The legacy of the 2012 Act is a dysfunctional superstructure which there are no rational grounds for retaining, and the now widespread recognition that this is the case should make getting rid of it relatively easy. But there will still be a storm of rhetoric and powerful interests to be faced down, and this

means that the reasons for getting rid of the Act, and of private provision of clinical care, need to be kept clearly in mind.

First, the public need to be constantly reminded that markets are unable to produce good health care, let alone good health care for all. In fact a 2003 discussion paper published by the Treasury succinctly listed the reasons: the 'information asymmetry' that exists between patients and doctors, as opposed to the perfect information assumed in free market theory - the patient has to trust the provider's judgement; the inherent monopoly enjoyed by most hospitals; the impossibility of transferring risk to private providers (i.e. of letting a hospital on which a community depends close); the perverse incentives involved in private medical insurance (avoiding higher-risk patients) and for-profit clinical care (overtreatment, cutting quality); and, not least, as the recent history of the NHS has demonstrated in spades, the prohibitive cost of making and effectively monitoring enforceable contracts because of the technically complex, personal, collaborative and judgement-based nature of good health care.[18] Not mentioned in this catalogue, but equally important, is that the trust that patients need to have in doctors can be fatally compromised as soon as doctors are seen to be concerned with financial advantage - whether their own, or that of some private company.

These arguments are all the more important given that private companies continue to be offered new ways of making money from the NHS. Although the services so far 'unbundled' from NHS providers and awarded to private providers have not yet yielded profits on a scale large enough to attract major multinational companies, that is not to say there is no likelihood of this changing. The value of clinical services commissioned from private providers by CCGs and NHS trusts has steadily increased since 2002-03, when it was some £2 billion, reaching £8.7 billion in 2015-16, which means that their collective market power and policy influence has grown.[19] The 'new models of care' being developed in England's 44 'local health systems' will be embodied in contracts that private companies might well secure if they could see a serious prospect of long-term profitability. The massive uncertainty about the future arising from the funding crisis, together with the secretive and extra-legal nature of the Sustainability and Transformation Plans programme, means that few possibilities are excluded.

Reversing the trend to privatisation should be a priority, if what has already happened in hospitals is not to be extended to more and more other health care

settings. The 2012 Act has forced NHS clinical services to conform to a business model that distorts and degrades them. Examples are legion. Thus a hospital consultant may not refer a patient to another consultant in a different specialty in the same hospital. Unless a case is urgent, serious, or fits an already agreed 'pathway', the patient must be sent back to his or her GP for a new referral; failure to do so means that the CCG may not pay for it. In mid-2016, hospitals were facing a 3 per cent annual increase in demand, and a 2 per cent annual cut in the tariff for the treatments they provide, in order to force them to find efficiency savings. But, as noted earlier, the expectation of an annual improvement in efficiency of 2-3 per cent, which is normal in many businesses, can't be applied to health care. A bank can increase its productivity by making us use ATMs, and a supermarket can make us do our own checkout, but, notwithstanding the government's current economy-driven enthusiasm for 'self care', we are not capable of providing much of our own health care. The effect of a 2 per cent annual cut is mainly a 2 per cent annual increase in stress, and failures. Meanwhile a hospital can be fined by a CCG for failing to meet any key provision of its contract, which means that some performance measures become targets that hospital staff are under pressure to meet regardless of patient needs, and even patient safety.

This pressure is passed down the line. The disclosure - even to managers - of resulting problems which might attract criticism from the commissioning CCG, or the Care Quality Commission, is unwelcome. From this comes a culture of fear, and the persecution of whistle-blowers. Nursing staff leave, leaving wards short-staffed; the nurses then join staff agencies which charge the hospital half as much again for covering the vacant posts. Instead of being trusted and helped to do their professional best, staff are audited, awarded ratings, named and shamed. Unsurprisingly, at the other end of the hierarchy, in 2015 trust chief executives were lasting on average just three years - the job is too full of contradictions and unfulfillable demands.

The alternative

A clean break

What is needed is a definitive break with the business model, and its replacement with one based on four central principles.

First, for the reasons already mentioned, for-profit provision of NHS clinical

services must be wound down and terminated.[20]

Second, the dependence of the NHS on trust in the professionalism and ethical commitment of its workforce must be recognised.

Third, in order to underpin that trust, new forms of local democratic accountability must be developed so that it does not rely solely on the professional training and self-policing of the professionals. The public must trust and support the NHS workforce, and the workforce must accept a new level of openness towards the local publics it serves, and whose taxes pay its salaries - reporting routinely, consulting genuinely and responding honestly to public input, and sharing important policy decisions. A significant element of local accountability was introduced in the 1970s in the form of Community Health Council, but it was abolished once the marketisation drive gathered pace after 2000. CHCs were valuable but they were reactive, and not equipped or trained to make informed contributions to improvement. What is needed today is active local involvement in the management of hospitals and other service providers, with a structured mix of skilled and experienced personnel (on the lines of the pre-Ofsted inspectors of schools) and local lay representatives, acting as advisors more than as judges, and producing periodic reports that the local public can recognise as relating to their needs.[21] Universal standards and coverage need to be assured from the centre, via regional teams, as with the old health authorities, while local delivery systems are allowed to vary in light of local needs and wishes.

Fourth, a radically expanded approach needs to be adopted towards public health, so that all economic and social policy starts to be looked at as a dimension of health policy.

Within a restored but democratised system of public provision, a host of important issues will need to be grappled with. Many of them, such as those concerning the best distribution of specialist hospital resources, are highly complex, and debates have often been muddied by vested interests and by a centrally-driven priority of saving money at all costs. Strong ministerial leadership will be needed to change this. Here there is space to consider briefly just four issues that will call for urgent attention - funding, primary care, mental health, and public health.

Funding

There is no objective level of cost beyond which a universal health service is 'unaffordable', as the protagonists of charging for health care imply. It would be an exaggeration to say that the only obstacle to better funding is a disinclination on the part of people who can afford private insurance to help to pay for health services for everyone else: there is also a more general aversion to taxes produced by decades of right-wing attacks on the state and bidding for votes at elections with promises to cut taxes. But a large majority of the public have consistently indicated their willingness to pay more tax for the NHS;[22] and in all the OECD countries which pay for health care from taxation the share of GDP devoted to it has risen as steadily as in countries which do not.

Writing in 2002, when the share of the UK GDP spent on health was estimated to be 7.7 per cent, Sir Derek Wanless expected it to rise to about 11 per cent by 2022-23; yet this level has already been reached in a number of countries including the Netherlands, Germany, Switzerland and Sweden, not to mention the 16.3 per cent reached in the US. As the American economist William Baumol showed, the inherent dependence of health care on the highly skilled labour of clinical and technical staff and their necessary support staff, combined with the continual discovery of new treatments, means that the share of GDP that needs to be devoted to it will constantly tend to rise. 'Productivity' per health worker will not keep pace with productivity in other fields. But the effect of productivity increases in other fields is to continually reduce the share of GDP that needs to be devoted to them, meaning that more can be devoted to health.[23]

The level of resources actually committed to health is thus always a political choice. The gap between what the UK now spends on health and what is spent by several other countries with which we like to compare ourselves is about one percentage point of GDP (9.9 per cent compared with 10.9-11.1 per cent). That is a big difference: closing the gap would add some £18 billion a year (18 per cent) to the current Department of Health budget of £120 billion - more than closing the current shortfall.[24] But the government's austerity spending plans imply a reduction in the share of GDP spent on health by 2020-21.

Meanwhile a cut of over 40 per cent in grants to local authorities since 2010 has also increased demand for NHS care from people who no longer have access to day

care centres, or whose domiciliary visits and other social services have been pared down to a level that no longer meets their needs, or have been withdrawn altogether. NHS hospitals in England are stuck with an estimated annual cost of £900 million for patients who should be discharged, but who can't be because local authorities are unable to provide the local facilities they need.

The NHS is also currently saddled with the costs of operating as a market. We don't know how much of the total administration cost of the NHS in England is due to this, because since the 1970s governments have declined to report on it, but the additional administrative costs of operating like a market have been conservatively estimated at £4.5 billion a year.[25] Until the 1980s the administrative costs of the NHS were 5 per cent of the budget; in 1997 they were estimated at about 12 per cent;[26] and in 2003-04 they were estimated to have been about 13.5 per cent.[27] But over the next few years a full proto-market was introduced, involving billing for every completed treatment, legally binding contracts, litigation, etc. Unsurprisingly, the number of senior managers and financial, HR and IT staff, with ancillary staff to support them, increased again, as did spending on lawyers and consultants. The total cost of the administration of the NHS in 2016 is unknown.[28]

Another market-driven cost is the £700 million of interest now being paid annually for hospital PFI contracts, which largely account for the biggest of the 'provider deficits' which figured so prominently in media coverage of the NHS at the close of the 2015-16 financial year. Responsibility for this burden lies squarely with the Blair-Brown governments, which chose to use private financing as a means of reducing the amount of public borrowing that was shown in the national accounts. Under the emergent business model, the costs were to be borne by the individual hospitals concerned, not shared across the NHS. The government also failed to provide the necessary expertise to hospital trusts to prevent bad deals being made. Patient services in these hospitals have suffered, while their managements have been portrayed as incompetent.

Getting rid of the failed market project will eventually save significant sums of money, but it would be unwise to expect an early or large 'de-marketisation dividend'. What is needed above all is an honest political decision on the share of GDP to be allocated to the NHS: if we want a good service for everyone we must pay for it. As the Barker Commission - an independent commission established by the King's Fund and led by a prominent banker - pointed out, this is eminently

achievable by relatively modest tax increases which, as opinion polls have consistently shown, a high proportion of voters are willing to pay for.[29]

The government expects the current funding shortfall to be closed by efficiency savings. NHS England has proposed five new models for delivering care which it hopes will improve patient care while also saving money - and it has funded a total of fifty 'vanguard' sites to try them out.[30] Some of them appear obviously sensible: for example 'enhanced health in care homes' means having a single GP practice care for all the residents in a residential care home, and enhancing the practice's specialist expertise in geriatric care. Since care home residents are among the highest users of hospital care this measure has the potential to reduce admissions, benefitting the patients concerned and reducing the need for hospital beds.[31]

But the adoption or otherwise of any of the FYFV's new models of care should, of course, depend on independent evaluations - very few of which have been seriously undertaken on any of the new models rolled out under the marketisation programme. No evidence has been provided that the FYFV's new models will save money, or that they will really be good for patients when all their externalities are taken into account. Adopting reforms without any evidence that they are likely to achieve their intended effects has become so habitual in the NHS as to be almost celebrated as virile and audacious (cf Michael Gove's view that we have had enough of experts). A critical approach is essential. For example, another sensible-seeming model is 'urgent and emergency care networks', whereby NHS hospitals share both administrative costs and expertise in emergency care. In this instance we need to ask why, if the sharing of back-office work saves money, it should not be shared on an even wider basis; and how much of the work carried out is in any case due to the costly payments system created by the defunct competition model; and why sharing medical expertise should not be normal and widespread.

In addition to the vanguard models, a number of other initiatives are aimed at 'place-based' commissioning and decision-making, under the rubric of 'devolution', using broad powers provided under the Cities and Local Government Devolution Act passed in January 2016. The main example of this is 'Devo Manc', in which the budgets for both NHS care and adult social care have been devolved to the Greater Manchester Combined Authority, but similar experiments are being conducted elsewhere. The key issue here is how social care, which is not free to the recipient of the care, is to be merged with health care, which is. Integration of health and social

care is clearly needed, but it must imply free social care, not charges for health care.

Besides taking a sceptical approach to the new models promoted by the FYFV, we must not be afraid of restoring old models. Market advocates like to dismiss anything based on the values of the post-war settlement as 'old', 'not fit for purpose', etc. But the issue ought to be not whether something can be considered 'modern', but whether it is a rational way of meeting the needs of a good health service. The truth is that throughout all the successive reorganisations of the NHS remarkably little has actually changed in terms of health care. GPs and hospital clinicians and community-based specialists have gone on treating patients and improving their skills and adopting new treatments as best they can, regardless of the often expensive and always disruptive changes in the formal structures of the service. (As we have seen, the drive by Simon Stevens for 'integration' has led him to call for the formation of 'shadow' administrative structures that closely resemble the official structures of the 'old' NHS - because they serve a necessary function in an integrated service.)

The one kind of change that government can make which has historically been shown to make a positive difference to patients is to increase the level of funding - upgrading facilities, increasing the numbers of staff and raising their morale, and dramatically improving access and quality. During the Blair years, when funding rose by 30 per cent in real terms, public satisfaction with the NHS moved steadily up, reaching a record high of 70 per cent in 2010; it then dropped sharply and has since hovered around 60 per cent. Securing an adequate and stable funding formula for the NHS would be a true innovation.

Primary care

Ninety-six per cent of primary care in England is provided by independent GP partnerships and so has not been a major focus of the marketisation drive, but it has been under other pressures to change. The 'single-handed practitioner' model of the doctor who knows the family's history, deals with common childhood infections and refers more serious conditions to hospital, has been overtaken by advances in diagnostics and treatments, the rising proportion of patients with long-term conditions requiring non-hospital management, and people's rising expectations of what the health service should provide. These changes call for a primary care system

with access to a range of diagnostics, a range of specialists in chronic conditions, facilities for treating minor injuries beyond the level of a cut finger, and close connections with both hospital specialists and the providers of social care. All this also implies shared electronic records. In England, as in all rich countries, primary care has been evolving to meet these needs. But progress has been uneven and slow, thanks to GPs' self-employed, small-business status. So long as that status remains, change can be induced by financial incentives and subsidies, but not commanded.

But GP services are now widely agreed to be facing a crisis. Over the four years 2010-11 to 2014-15 spending on general practice fell slightly, both absolutely and as a share of the total NHS budget. Yet during this same period the number of people over 85 rose by 9 per cent, while the number receiving free social services was cut by 25 per cent, and the services that were provided - largely by private companies - became increasingly inadequate.[32] Combined with the growing number of patients with chronic conditions and the drive to keep them out of hospital, these cuts have led to unprecedented levels of pressure on GPs, as well as to the more publicised pressures on A&E departments.

A further problem for GP services is that funding doesn't take adequate account of variations in need. In 2013-14 payments to the few corporate providers of NHS primary care in 'under-doctored' areas (accounting for just 4 per cent of all NHS GP services) were £192.45 per patient, compared with the £131.45 per patient paid under the standard General Medical Services GP contract - a measure of the incentive needed to get private companies to do the work that GP partnerships routinely undertake in areas with very similar needs.[33] In these most economically deprived areas patients have a health status equivalent to that of people 17 to 20 years older than them in the wealthiest areas, and their health problems are often compounded by low health-literacy, inadequate social support and the threat of violence. Housing and employment is frequently insecure or inadequate. Health professionals find their time taken up with advocating for welfare before they can engage with patients' health needs.

The result of all these pressures is that, to avoid burnout, more and more GPs have chosen to go part-time, and many plan to retire early; only a minority of current GP trainees plan to work full-time. And in April 2016 12 per cent of all GP positions in England were unfilled, compared with 2 per cent in 2011.[34] Many practices cannot even find locums to fill vacant posts. Some areas are facing the

closure of a substantial number of practices.

In response NHS England has produced a plan, the *General Practice Forward View,* which promises increased funding, a large increase in GP recruitment (5000 more GPs by 2020-21), upgraded IT systems, new kinds of practice staff, such as clinical pharmacists and 'physician associates', and more trained practice nurses. It also pledges support for new models of primary care that promise to widen its scope; to integrate GP care with community health care (non-hospital specialist care) and social care; and to greatly increase practice sizes, with new diagnostic and other facilities concentrated in a limited number of primary care 'hubs' (which sound very like the 'Darzi centres' unsuccessfully promoted by New Labour in 2009).

A fast-growing proportion of GPs - a quarter of the total in 2015 - are now salaried employees of their practices, while a survey of GPs in April 2016 found that just over half of the GP partners who responded would swap being partners for being salaried 'if offered the right deal'; and a 2015 BMA survey found that only a quarter of salaried GPs wanted to become partners.[35] Some GPs have already exchanged their partnerships for a salary, and some whole practices have been taken over by hospital trusts or community health trusts, putting all the GPs on salary and integrating primary and secondary care in the process. So it is possible that general practice could become a salaried service like the hospital service, finally overcoming the long-standing lack of integration between them. This eventuality would correspond with one of the 'new models of care' proposed by the FYFV, under the title of 'Primary Acute Care' systems.

But an alternative model has also emerged, in the formation of 'super-practices' and federations. In super-practices the local surgeries relied on by patients remain, but as branches of a single business in which economies of scale make it possible to offer patients access to a range of specialisms and diagnostic facilities in a few larger 'hubs'. Federations or networks - formed by a large and growing proportion of practices - cover all the patients for which a given CCG is responsible. Currently covering an estimated 75 per cent of all registered patients in England, these federations can achieve the scale needed to win contracts to provide the additional services that CCGs want to be available for all patients, but which not all the individual practices involved can offer - such as evening opening hours, minor surgery, or health checks for people with learning difficulty.[36] Some super-practices and federations are embryonic versions of another new model promoted in the

FYFV, 'Multispecialty Community Providers'.[37]

Most GP federations and some super-practices are limited companies. The potential that has therefore arisen for the conversion of a cottage industry of small partnerships into a sector consisting of substantial companies could present a serious challenge to the NHS as a public service. The initial reason for establishing super-practices and federations as for-profit companies may be to serve the best interests of patients, but company law requires shareholders' interests to come first. If shareholder-based GP federations became free to sell the goodwill in their contracts (which GP practices are not at present allowed to do), large companies might be tempted to move in, significantly altering the balance of forces in health policy-making in primary care and risking the downward pressure on quality that profit-driven provision entails.[38]

In the end the question of the best organisational form, or forms, for primary care needs to be disentangled from the ideological and cost-cutting issues that have dominated discussion for the past several decades. Instead of asking whether the best model is a corner shop, a supermarket, or a government department, the starting-point should be to identify the distinctive role that general practice can play in the health service as a whole: i.e. providing continuity of care; managing complexity and uncertainty in patients' conditions; knowing, and being able to work with, local communities and local services; using healthcare resources parsimoniously; ameliorating healthcare inequalities; and providing holistic care, dealing with the whole person and not just their individual problems.[39] The aim would then be to support this role with whatever structures will best enhance it, with funds distributed to reflect local needs.

Mental health

In 1999 the Blair government adopted a National Service Framework (NSF) for mental health, reflecting a professional consensus on the standards of care that should be met, and which were widely regarded as reasonable and feasible.[40] During the years 2003-2008, when NHS funding was sharply increasing, good progress was made towards achieving the goals set in the NSF.

But since 2010 its implementation has been sacrificed to austerity. Mental healthcare funding has remained stuck at 10 per cent of NHS spending (compared

with 50 per cent for acute [hospital] care), though rates of mental illness have increased.[41] Mental illness is not generally seen as life-threatening, yet people with severe mental illnesses have life expectancies that on average are fifteen to twenty years shorter than those of the general population. They die from a wide range of treatable physical illnesses which are not treated or managed effectively because their mental illnesses make this so difficult. Among males aged 15 to 34, suicide is the leading cause of death, and most of those who kill themselves have been in contact with mental health services in the month before they die. Disabling mental illness is a huge burden, and one borne by all sectors of society, often without any government support. Meanwhile almost three-quarters of the 85,000 people in prison in England and Wales are mentally ill.[42]

The government's 2012 promise of parity of status for mental and physical health has not been kept. Instead of being expanded in order to provide alternative facilities to the asylums closed in the 1980s, community-based facilities for mentally ill people have contracted. Most day hospitals, which offered support and continuity of care for people with long-term mental illnesses, have been closed: the NHS Choices website currently lists 32 for the whole of England, and just one for the whole of London. And following a cut of 39 per cent in the number of psychiatric acute hospital beds between 1998 and 2012, still further cuts have been made. In 2015 91 per cent of adult psychiatric wards were operating at occupancy rates above the 85 per cent maximum recommended by the Royal College of Psychiatry, many of them at well over 100 per cent.[43] Only the most acutely ill patients can now be admitted, too often to hospitals far away from family support, and they are often discharged too soon in order to make room for others. And wards overcrowded with highly disturbed patients are anything but good therapeutic environments.[44]

On top of this, the marketisation of care has had particularly damaging effects on the treatment of mental health. To create a 'tariff' according to which mental health treatments could be paid for on a market basis, mental illnesses were classified into 20 diagnostic 'clusters', with a treatment and price for each one, in spite of the fact that the conditions of many, if not most, mentally ill patients cannot be readily categorised in this way. And payments were based on outcomes, the most important of which was 'recovery' (on the model of time-limited acute physical illnesses), even though many mental illnesses are chronic and need long-term care, and care from a variety of collaborating providers (including physicians and social workers). The

result is that the treatments a patient actually needs often can't be provided because there is no way of getting them paid for.

The case for restoring the principle that funding should support professionally determined standards of care, such as those laid down in the NSF for mental health in 1999, is unanswerable. The starvation of mental health services is a scandal, and the attempt to commodify them would be almost comic if the consequences were not so often tragic. Both the lack of funding and the tariff classification system need to be reversed, without equivocation.

Public health

> Preventive medicine, which is merely another way of saying health by collective action, builds up a system of social habits that constitute an indispensable part of what we mean by civilization.
>
> Aneurin Bevan, *In Place of Fear*

By far the most important determinants of health and ill-health are politically-determined economic and social conditions. In rich countries, even those where health care is freely available as it is in the UK, health care accounts for only a small part of how long people can expect to live, and live free from disability. Whether it is physical or mental health, people at the bottom of the hierarchy of income and wealth have the worst health, starting in childhood. Within England, people living in the poorest neighbourhoods on average die seven years sooner than people living in the richest areas, and have seventeen fewer years free of disabilities. And among the richest countries the least equal ones have the lowest life expectancy.[45] Among other consequences, in comparison with services in less unequal countries the NHS is coping with a significantly greater burden of illness. Sir Michael Marmot estimated in 2010 that NHS costs associated with inequality were in excess of £5.5 billion a year. He also estimated that health inequality in England accounted for productivity losses of £31-33 billion a year, and lost taxes and higher welfare payments in the range of £20-32 billion a year (equal to some 4-7 per cent of total government spending).[46]

The health implications of economic inequality were painfully illustrated by the Blair and Brown governments. They gave unprecedented increases in funding to

the NHS, but left office with economic inequality greater than when they arrived, and greater than at any time since the 1930s. Having accepted the dominance of financial capital and the resulting rise in inequality, Gordon Brown tried to mitigate its social impact with a series of compensatory measures such as tax credits, Sure Start, Schools for the Future, the National Minimum Wage, and increased benefits for pensioners. But only the tax credits and benefits made the hoped-for impacts - and they were swiftly curtailed or even cancelled by the Coalition government that followed.

The lesson is that a progressive health policy calls for a more radical economic and social policy than anything that has been on the political agenda since the 1960s. Health policy should include breaking the grip of the City on economic policy, reforming the tax system, embarking on a major infrastructure programme and securing greater equality via better jobs, better education and better housing, and adopting environmental measures such as cutting carbon emissions.

If this sounds radical, it is only because the dominance of neoliberal ideology has made it seem so. Measures to implement these objectives have been well developed in a series of major analyses commissioned by successive Labour governments, from Sir Douglas Black's 1980 report on *Inequalities in Health* to Sir Michael Marmot's 2008 review, *Fair Society, Healthy Lives: a Strategic Review of Health Inequalities in England post-2010*.[47] Their recommendations converge closely, but none of them has ever been seriously acted on. The Marmot review, published shortly before Labour lost power in 2010, is a sophisticated analysis and summing up of the issues. Building on its predecessors, it proposed a range of policies aimed at changing the determinants of ill health - measures to secure early childhood wellbeing, good jobs for all, and healthy living environments, and measures to combat climate change. But since 2010 government policy has if anything aggravated the problems the Marmot review was aimed at alleviating.

The NHS has been largely configured as a 'national sickness service', focused on treating the sick rather than on preventing illness. Nonetheless it has always had a public health dimension known as 'prevention', concerned with protection against epidemics and other hazards, and with specific causes of ill health that can be alleviated within the existing social and economic framework, such as smoking, alcohol and drug abuse, excess consumption of salt and sugar, and lack of exercise. But the focus has been mainly on 'nudging' people to take individual

responsibility for their own health, not on regulating the industries concerned with these major causes of disease. And in a further shift away from national government responsibility for action on public health, much of it was transferred to local authorities under the 2012 Health and Social Care Act. While some public health experts welcomed the move as making the efforts of public health personnel more likely to be effective than within an NHS public health 'silo', local directors of public health were given small staffs and purely advisory powers. Operating in a climate of swingeing cuts to local government budgets, they have had at best a very limited impact, and have themselves been subjected to a financial cut that the government would not have made to the NHS budget.[48]

This needs to change. Adult social care needs to be integrated with NHS care to give prevention measures a better chance, and the status of public health professionals needs to be raised so as to support health-oriented economic and social policies at the national level. The consequence of not giving sufficiently high status to public health was painfully illustrated in August 2016 by the government's abject failure to adopt the policies to halt the obesity epidemic - and the epidemic increases in diabetes, cancer, osteoarthritis, and vascular disease which will follow - that had been recommended by its own advisers.[49]

Marmot pointed out in 2010 that measures to prevent ill health accounted for just 4 per cent of the NHS budget, and recommended a major increase in spending on it, to 0.5 per cent of GDP. In 2015, however, the share of GDP spent on public health was less than 0.3 per cent, and prevention was only a part of that. The challenge for any progressive government is to be serious about implementing the programme set out by Marmot and his predecessors, and to make an assault on the causes of ill health a priority in all areas of policy.

For thirty years health policy has followed a false trail. Will a new generation of politicians have the intelligence to acknowledge this, and the determination to match the public's continuing and strong support for the NHS with the trust, resources, and much more egalitarian social and economic policies needed to let it succeed?

Postscript: the shape of the NHS in 2021?

In mid-2016, when this article was written, the 44 Sustainability and Transformation Plans (STPs) called for by NHS England at the end of the previous year had not yet

been made public. But by the end of November most of them (38/44) had been published. Although most were described as 'drafts' and did not include the detailed calculations on which they were based, their main implications were clear.

Their overriding aim was to end up spending about 16 per cent less in 2021 than would otherwise be needed to maintain services at their 2014 level. To achieve this reduction in outlay a large part of the care hitherto provided by hospitals will in future be provided by a reorganised mix of general practices and GP federations, specialist community health services, and adult social services. In areas with several hospitals one or more will be downgraded or even closed, and in areas where rapid population growth is expected no new hospitals will be opened. In addition, the skill-mix in primary and community care will be changed. Many GPs will be replaced by nurses and 'physician associates', reducing the salary bill.

This raises two questions. One is whether care provided in this way will really be of the same standard, or as comprehensive, as in the past. The plans invariably claim that it will actually be even better, but in the view of most policy experts, clinicians and well-informed patients it is more likely to be worse. Second, are the assumptions on which the STPs are based realistic? Can the plans really be implemented? This too seems more than doubtful.[i] Not enough funding is on offer to provide all the new non-hospital facilities that will be needed, or the trained staff to work in them. Moreover hospital staff and GPs are already working under severe stress and very few of them have even been consulted about the radical changes to their working lives envisaged in the plans, let alone offered training for the new roles and relationships involved.

Senior NHS managers and health policy experts have been united in declaring that good health care can no longer be provided with the existing level of funding. But no further funding for health of social care was provided in the 2016 autumn budget statement: Mrs May told them to stop 'whingeing'. Per capita funding is instead projected to *fall* by almost 1 per cent a year over the next four years, while costs will rise by about 3 per cent a year, thanks to health cost inflation and technological advances.[ii] The implication is that the NHS in England will be radically reshaped while simultaneously being subjected to a massive cut in its real income.

The effects are unpredictable. Untested solutions and failures of implementation seem bound to create an uneven patchwork of healthcare provision. There could be serious losses of clinical staff (compounded by Brexit), declining standards of

care, a contraction of coverage, escalating waiting times for elective surgery, local service breakdowns, a major revival of private health insurance and an expansion of the share of private beds in NHS hospitals. Some areas could be tempted (or even instructed) to contract with private companies to push through the non-hospital service reorganisations that are called for. Or there could be a mounting public reaction - perhaps even precipitated by another Mid Staffs-style tragedy - forcing a change of course, and even the abandonment of the fiction that the 2012 Health and Social Care Act is still operative. All that is really clear is that the reference point for whoever undertakes the task of rebuilding of the NHS on progressive lines will no longer be the once-unified NHS, or the failed market model, but the tangled legacy of the Five Year Forward View's extra-legally imposed nostrums.

I am very grateful to Maryam Aslany for technical help with Figure 1.

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Notes

1. The chief executive of NHS Providers, Chris Hopson, declared that that without more resources the alternatives were 'more draconian rationing of access to care, formally relaxing performance targets, shutting services, extending and increasing charges, cutting the priorities the NHS is trying to deliver or, more explicitly, controlling the size of the NHS workforce'. *Observer*, 10.9.16.

2. Two cases in particular have highlighted this - the closure in 2000 of the A&E department at Kidderminster Hospital, which cost the seat of a junior Labour minister, and the threatened downgrading of the A&E department at Lewisham Hospital in 2013, which cost the Secretary of State a humiliating court defeat.

3. Mark Button and Colin Leys, *Healthcare Fraud in the new NHS market - a threat to patient care*, Centre for Health and the Public Interest 2013: https://chpi.org.uk/wp-content/uploads/2012/06/CHPI-Healthcare-Fraud-a-threat-to-patient-care1.pdf.

4. Calum Paton, *At what cost? Paying the price for the market in the English NHS*,

Centre for Health and the Public Interest 2014: https://chpi.org.uk/wp-content/uploads/2014/02/At-what-cost-paying-the-price-for-the-market-in-the-English-NHS-by-Calum-Paton.pdf. The government claimed that the cost was £1.5bn and, implausibly, that this was offset by £1bn a year in administrative savings.

5. www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf.

6. Adam Roberts, Louise Marshall and Anita Charlesworth, *A Decade of Austerity?*, Nuffield Trust, December 2012: www.nuffieldtrust.org.uk/sites/files/nuffield/121203_a_decade_of_austerity_full_report.pdf.

7. *NHS Five Year Forward View Recap briefing for the Health Select Committee on technical modelling and scenarios*, NHS England May 2016: www.england.nhs.uk/wp-content/uploads/2016/05/fyfv-tech-note-090516.pdf. Right Care is a programme to secure better use of resources in primary care, especially to reduce unplanned hospital admissions of higher-risk patients (see www.rightcare.nhs.uk/wp-content/uploads/2011/06/Right-Care-Forward-View-2015-191.pdf).

8. Chris Hopson, quoted in the *Health Service Journal*, 12.9.16: www.hsj.co.uk/topics/finance-and-efficiency/hopson-new-care-models-a-15-year-journey/7010500.article.

9. For an example see Mary Burnett, *'Transforming Services Together': what does East London's plan for health services imply for East Londoners?*, Centre for Health and the Public Interest, October 2016.

10. Written answer by the health minister George Freeman: 'The Sustainability and Transformation Plans (STP) has no legal basis', *Hansard*, 13.6.16.

11. Rebecca Thomas, 'CCG leader: STP approval process "not democratic"', *Health Service Journal*, 2.6.16: www.hsj.co.uk/hsj-local/pcts/city-and-hackney-teaching-pct/ccg-leader-stp-approval-process-not-democratic/7005242.article.

12. And former chief executives of NHS Trusts don't hesitate to say so publicly: see www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/The-chief-executive-tale-Kings-Fund-May-2016.pdf; and www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/leadership-vacancies-in-the-nhs-kingsfund-dec14.pdf.

13. Colin Leys, 'Living with a zombie', *The Commissioning Review*, Summer 2016.

14. Dave West, 'Stevens floats "combined authorities" for the NHS', *Health Service Journal*, 19.5.16: www.hsj.co.uk/newsletter/sectors/commissioning/exclusive-stevens-floats-combined-authorities-for-the-nhs/7004897.article?WT.tsrc=email&WT.mc_id=Newsletter307.

15. Crispin Dowler, 'Regulators push for headcount cuts in last ditch drive to curb deficits', *Health Service Journal*, 15.1.16: www.hsj.co.uk/topics/finance-

and-efficiency/regulators-push-for-headcount-cuts-in-last-ditch-drive-to-curb-deficits/7001668.article.

16. Dave West, 'Solve deficits and protect patients or face suspension, Hunt warns boards', *Health Service Journal*, 15.1.16: www.hsj.co.uk/topics/finance-and-efficiency/solve-deficits-and-protect-patients-or-face-suspension-hunt-warns-boards/7001634.article.

17. www.cqc.org.uk/sites/default/files/20160115_letter_nhstrusts_quality_and_finances.pdf. See also Helen McKenna and Phoebe Dunn, *What the Planning Guidance Means for the NHS: 2016/17 and beyond*, Kings Fund, February 2016: www.kingsfund.org.uk/publications/what-planning-guidance-means-nhs.

18. H.M Treasury, *Public Services: meeting the productivity challenge. A discussion document*, April 2003. Gordon Brown incorporated some of the Treasury's analysis into a much-publicised speech to the Social Market Foundation (www.smf.co.uk/publications/a-modern-agenda-for-prosperity-and-social-reform-opportunity-security-prosperity/), but he seems to have made no protest when successive Labour health secretaries pressed ahead with preparations for a healthcare market. For evidence of the failure of contracting to manage quality of provision see *The contracting NHS - can the NHS handle the outsourcing of clinical services?*, Centre for Health and the Public Interest 2015: https://chpi.org.uk/wp-content/uploads/2015/04/CHPI-ContractingNHS-Mar-final.pdf.

19. Equal to 7.6 per cent of all Department of Health current spending. See Department of Health Annual Report and Accounts 2015-16, Table 10.

20. Like all public services, the NHS depends on extensive non-clinical private sector inputs and will necessarily continue to do so. But the too often uncritical drive to outsource as much as possible to the private sector (sharply illustrated by very poor PFI contracts and the generally inadequate contract monitoring revealed by the Public Accounts Committee) needs to end. On outsourced clinical services see *The contracting NHS - can the NHS handle the outsourcing of clinical services?*, Centre for Health and the Public Interest, March 2015: https://chpi.org.uk/wp-content/uploads/2015/04/CHPI-ContractingNHS-Mar-final.pdf.

21. For a persuasive vision of this conception of public engagement see Michael Rustin, 'Rethinking Audit and Inspection', *Soundings* 26, spring 2004.

22. *British Social Attitudes 33*, *NHS*: www.bsa.natcen.ac.uk/media/39062/bsa33_nhs.pdf.

23. W.J. Baumol and W.J. Bowen, *Performing Arts: The Economic Dilemma*, Twentieth Century Fund 1966, and W.J. Baumol, 'Health care, education and the cost disease; a looming crisis for public choice', *Public Choice* 77, 1993.

24. Data from latest OECD table using new international accounting standard

which adds spending on much social care to health spending. Such international comparisons involve a large degree of interpretation of data collected and recorded in different ways in different countries, but the order of magnitude of total differences is probably not misleading.

25. Calum Paton, *At What Cost? Paying the price for the market in the English NHS,* Centre for Health and the Public Interest, February 2014.

26. Charles Webster, *The National Health Service: A Political History*, Oxford University Press 1998, p203.

27. K. Bloor et al, *NHS Management and Administration Staffing and Expenditure in a National and International Context*, University of York 2005, commissioned by the Department of Health. It became public only when released to and cited by the Commons Health Committee in 2010.

28. The total cost of administering the US market system is generally reckoned to be about 33 per cent.

29. *A new settlement for health and social care*, The King's Fund 2014: www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Commission per cent20Final per cent20 per cent20interactive.pdf.

30. See www.england.nhs.uk/ourwork/futurenhs/new-care-models/.

31. NHS England's Director of New Care Models has claimed that 'vanguards' have already achieved 20 per cent reductions in A&E admissions. It seems possible, or even likely, that this has been significantly due to better medical care in care homes: www.hsj.co.uk/sectors/acute-care/whats-new-in-care-models-david-dalton-answers-our-questions-on-the-future-of-chains/7005749.article.

32. *The future of the NHS? Lessons from the market in social care in England*, Centre for Health and the Public Interest 2013: https://chpi.org.uk/wp-content/uploads/2013/10/CHPI-Lessons-from-the-social-care-market-October-2013.pdf.

33. With an average of some 1500 patients per full time equivalent GP in England, the average payment of £136 per patient gives an average gross income of about £200,000 per GP, from which all the related costs of the practice must be found.

34. www.pulsetoday.co.uk/your-practice/practice-topics/employment/gp-vacancy-rates-at-highest-recorded-with-one-in-eight-positions-unfilled/20031836.article.

35. See Sofia Lind, 'Abandon ship: The partners bailing as their practices head for the rocks', *Pulse* 1 July 2016: www.pulsetoday.co.uk/your-practice/practice-topics/abandon-ship-the-partners-bailing-as-their-practices-head-for-the-rocks/20032160.article; and https://www.bma.org.uk/collective-voice/committees/general-practitioners-committee/gpc-surveys/future-of-general-

practice.

36. Nick Renaud-Komiya, 'Analysis: Size, spread and form of large scale GP groups', *Health Service Journal*, 6.1.16: www.hsj.co.uk/sectors/primary-care/analysis-size-spread-and-form-of-large-scale-gp-groups/7001169.article.

37. So far, however, existing super practices and federations do not seem to employ the consultants that the FYFV envisages moving out of hospitals to work in them.

38. This pressure has been well illustrated in primary care by Serco's out of hours contract in Cornwall and Take Care Now's similar contract in East Anglia; see *The contracting NHS - can the NHS handle the outsourcing of clinical services?*, Centre for Health and the Public Interest, March 2015.

39. I owe this exemplary formulation to Dr Jonathon Tomlinson.

40. *A National Service Framework for Mental Health: Modern Standards & Service Models*, Department of Health 1999: hwww.gov.uk/government/uploads/system/uploads/attachment_data/file/198051/National_Service_Framework_for_Mental_Health.pdf.

41. Sarah Lafond, Anita Charlesworth and Adam Roberts, *A perfect storm: an impossible climate for NHS providers' finances?,* The Health Foundation, March 2016: www.health.org.uk/sites/health/files/APerfectStorm.pdf; *Key facts and trends in mental health, 2016 update*, Mental Health Network, NHS Confederation Factsheet, March 16, p2.

42. *Mental Health Care in Prisons*, Prison Reform Trust 2016: www.prisonreformtrust.org.uk/projectsresearch/mentalhealth.

43. Helen Gilburt, *Mental health under pressure*, The King's Fund, November 2015: www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/mental-health-under-pressure-nov15_0.pdf.

44. David Bell, *Mental illness and its treatment today*, Centre for Health and the Public Interest, December 2013: https://chpi.org.uk/wp-content/uploads/2013/12/David-Bell-analysis-Mental-illness-and-its-treatment-today.pdf.

45. Richard Wilkinson, *The Impact of Inequality: How to make sick societies healthier*, The New Press 2005, chapter 4.

46. Sir Michael Marmot, *Fair Society*, Healthy Lives: a Strategic Review of Health Inequalities in England post 2010, p18.

47. The others are Sir Donald Acheson's 1998 *Independent Inquiry into Inequalities in Health* and Sir Derek Wanless's 2004 report, *Securing Good Health for the Whole Population*.

48. David Hunter, 'Public health: unchained or shackled?', in Mark Exworthy, Russell Mannion and Martin Powell, *Dismantling the NHS? Evaluating the impact of health reforms*, Policy Press 2016; George Osborne cut £200m (7 per cent) from the public health budget for local authorities in 2015.

49. Sarah Boseley, 'Childhood obesity: UK's "inexcusable" strategy is wasted opportunity, say experts', *Guardian*, 18.8.16: www.theguardian.com/society/2016/aug/18/childhood-obesity-strategy-wasted-opportunity-campaigners.

Notes for Postscript

i. For an analysis of the feasibility of the only plan for which some detailed calculations were available in October 2016 see Vivek Kotecha and Colin Leys, 'Transforming Services Together': what does East London's plan for health services imply for East Londoners? Centre for Health and the Public Interest, November 2016, https://chpi.org.uk/wp/wp-content/uploads/2016/11/CHPI-TSTE.London-paper-17Nov16-Final.pdf.

ii. Mirko Licchetta and Michal Stelmac, Fiscal sustainability analytical paper: Fiscal sustainability and public spending on health, Office for Budget Responsibility, September 2016, Table 1.1 and Chart 2.7: http://budgetresponsibility.org.uk/docs/dlm_uploads/Health-FSAP.pdf.