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## **REINVENTING THE NHS**

To follow the current debate about the future of the NHS would be to conclude that there are only two possible positions. The first is that a sleepy and inefficient NHS needs shaking up by the rigours of market discipline and competition. The alternative is that there is nothing much wrong with the NHS that can't be solved by more money and leaving a largely unreformed NHS to get on with it. The reality is that neither extreme position stands up to rigorous scrutiny.

The Government's approach certainly has the merit of simplicity. If a competitive market delivers choice and innovation when it comes to supermarkets, the argument runs, the same must be true in public services. According to this theory, the problem with the NHS is that it is a monopoly which has little incentive to improve efficiency because most patients (or "customers") cannot register their disapproval by going somewhere else.

The solution to this problem has been to create a pseudo-market in public health care where quality is rewarded and, equally importantly, failure is penalised. The main elements to this market are "patient choice", where the patient can choose from a list of providers, "payment by results", where each procedure attracts a particular tariff, regardless of the actual costs of provision, and "contestability", where market entry is encouraged by subsidies and guarantees to new entrants.

The limitations of this market-driven approach should be apparent to anyone who ever completed more than the first few weeks of an economics course, but unfortunately the Government seems oblivious to them.

The first problem is that markets have a tendency to reinforce existing inequalities, whereas the public good requires them to be reduced. The concept of a "fair" outcome is alien to market economics. Economics undergraduates are taught that the only thing that matters is efficiency – any resultant inequalities can be left to be dealt with by some other means. When patients are turned into consumers who shop around for the best deal, there will certainly be winners. The well-educated, articulate and mobile will increasingly dominate the best healthcare provision, just as they do the best education. But the vulnerable and marginalised will end up with the cast-offs.

The second problem is that entry and exit from the health market is far from the costless and smooth transition envisaged in the text books. A local hospital that cannot compete with a shiny new private unit will steadily lose patients and income and may eventually find that whole departments have to close. Before

long, the hospital and its staff become trapped in a downward spiral of falling morale, redundancies and the threat of closure. What the NHS needs is keyhole surgery, but what it is getting is amputation with a rusty hacksaw.

This painful process is an inevitable consequence of a market-driven approach to running the NHS. We should not be surprised that we see today simultaneously record sums being spent on the NHS and yet a majority of NHS Trusts running a deficit and planning cuts. Market mechanisms depend on the creation of winners and losers, and the losers are being told more ruthlessly than ever before that no-one is going to bale them out.

Of course, what is developing in the NHS at present is not a free market at all. New providers have been offered favourable prices to undertake NHS work – more than their “competitors” in the NHS would be paid – and are offered guaranteed volumes of work. This has led to the bizarre situation of NHS scanners lying idle whilst a more expensive privately-provided scanner operating from a trailer in the hospital car park is fully occupied.

The market also risks undermining the sharing of good practice within the NHS. If I am an NHS manager and know that my job depends on being more efficient than rival hospitals, the last thing I will want to do is share good practice with others. One of the curses of the NHS has been variability in standards within the NHS, and turning the NHS into a series of competing units is likely to reinforce those divisions.

In short, therefore, the simplistic market-led model of NHS reform is riddled with problems which will become steadily more acute as the reform process rolls out.

But are we therefore to conclude that nothing needs to be done, and that the only thing the NHS has lacked has been money?

With the UK now set to spend as much of its national income on healthcare as many comparable European nations we have a duty to look ever more closely at how that money is spent. A system which until recently had a million people on waiting lists hardly suggests great efficiency. If existing mechanisms for ensuring the delivery of efficient healthcare are inadequate, what else can be done if we reject the market-led route to driving up standards?

The key to reinventing the NHS, whilst remaining true to its founding principles, lies in a rediscovery of the notion of accountability. Within the NHS as presently structured, the power of those who pay for the NHS to shape what it does is extraordinarily weak and indirect.

But what if accountability and activity in the NHS were to be radically decentralised so that local people actually knew what was going on in their local NHS and could help to shape its strategic direction? What if we directly elected

people on the basis of their priorities for local health services and who were accountable if they failed to deliver? And what if local health bosses were in turn answerable to those people?

This would not just be a minor tinkering at the edges but could radically reshape the way the NHS was operated. Instead of being a top-down organisation, still at the mercy of ministerial whim (or mid-summer letters from NHS chiefs), the pattern of local health services would be determined locally, and accountable locally. Local NHSs could still work together where it made sense (eg to deliver specialist services which were only viable for larger population groups), but their primary focus would be on local health needs.

The precedent for this model already exists in Denmark, whose publicly-funded NHS is one of the most popular with its citizens in the whole of Europe. Its key feature is that despite a population only one tenth the size of England, the Danish healthcare system is itself run as fifteen smaller local units, each serving a population of typically a third of a million people. The result is efficient healthcare, with a public service ethos, accountable to local people.

The choice must not be between market mania or a nostalgic yearning for a mythical golden era. It is time to reinvent the NHS in a way that delivers top quality care in an efficient and accountable way. To do anything less would be the real betrayal of the National Health Service.

Note: This is a shortened version of a lecture given to the NHS Confederation on 8<sup>th</sup> November. Steve Webb is Lib Dem Shadow Health Secretary and MP for Northavon. Responses are welcome via [www.LibDemNHSWatch.com](http://www.LibDemNHSWatch.com)