



Wolves and Big Yellow Taxis: How Would Be Know If the NHS Is at Death's Door?

Comment on “Who killed the English National Health Service?”

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Abstract

Martin Powell suggests that the death of the English National Health Service (NHS) has been announced so many times we are at risk of not noticing should it actually happen. He is right. If we ‘cry wolf’ too many times, we risk losing sight of what is important about the NHS and why.

Keywords: National Health Service (NHS), Privatisation, Public Ethos

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Introduction

It happed on a day that the wulf came / and the child cryed as he was acustommed to doo / And by cause that the labourers supposed / that hit had not ben trouthe / abode styll at theyr laboure / wherfore the wulf dyd ete the sheep /

(Aesop's Fables – Caxton edition, 1484)

Oh don't it seem to go / That you don't know what you've got til it's gone...

Joni Mitchell – *Big Yellow Taxi*

Martin Powell is one of our most acute researchers on health policy. He writes in his piece ‘Who killed the English National Health Service’¹ that there has been something of a tendency to announce the death of the National Health Service (NHS), or at least that the NHS is in crisis in one form or another, for much of its history. He provides evidence going back to Aneurin Bevan, going through the 1980s, 1990s, and 2000s to support his claim. He provides evidence of previous death sentences for the NHS from a range of commentators and from political (often Labour) statements, and points to a statement from Simon Burns suggesting that statements about the end of free healthcare are so overused to have become meaningless. Powell's critique then is that ‘Accounts of the death of the NHS have been exaggerated’ (p. 2) and he makes a ‘request for clarity’ as to what critics of current policy in the present area exactly want to do, or what it is about the present form of the NHS they object to so much (the ‘weapon’ in the whodunit of the metaphorical murder). He concludes by suggesting that by crying wolf so many times in the past ‘alarmed cries may no longer be heeded’ (p. 2).

Is Powell right? Yes and No. And Yes. For most of the history of the NHS, someone or other has been claiming it is in crisis. But, I would argue, they were often right. And the reason for that is (because Powell is right on this too) that we have never

been that clear about exactly what it is we are talking about when we talk about ‘the NHS.’

What Is the NHS Exactly?

If by ‘the NHS’ we are referring to a free, universal, comprehensive health service, then we can get ourselves into a range of tangles very quickly. Did the NHS stop being ‘free’ when prescription charges were introduced (one of the things that prompted Bevan's resignation)? Did it become free again when they were briefly abolished in the 1960s? Does the NHS stop being ‘universal’ if it does not treat everyone the same way? If we ask alcoholics to stop drinking before they are treated, does that breach universality? If we do not provide treatment for every possible condition, does that mean the NHS is not comprehensive? These questions, although they can appear flippant, actually turn out to be pretty important. If we define the NHS in terms of it providing free, universal and comprehensive care, then we can compare what healthcare in England is like today against that standard, and explore the extent to which these principles are being eroded.

But the NHS is not just about these principles. For many people, it is also about the provision of public healthcare, and utilising private organisations in the delivery of care breach that, and so go against what the NHS is about.² The (still) current Labour policy about restricting private profit, and the Scottish National Party (SNP) policy of not allowing nonpublic providers to profit at all, reflect this approach. There are sensible grounds for thinking in this way – the NHS was created through a nationalisation of care providers, especially hospitals, and so the ‘public’ bit is clearly important. Equally, when things go wrong with private or not-for-profit provision (as at Hinchbrook hospital with Circle, or when the NHS made use of private clinics to put in place breast implants that were manufactured by the French company PIP), it is the public sector that ends up picking up the bill

as well as having to take over care provision. Those arguing that it does not matter whether the care being delivered comes from public or private providers tend to overlook the key point that, if the public sector has to act as a provider of last resort to guarantee provision, then the alleged gains of making use of private provision can be temporary and fragile. Ownership does matter.

Data examining the extent of private provision in the NHS can get rather confusing. On the surface of it, about 6% of NHS contracts by value go to the private sector, but at the same time in 2013/14 around 1/3 of all commissioned care contracts are now private. This is not a big increase from the situation in 2010, but is double that of 2006/7. The big gap between volume and cost comes through the private sector tending to win lots of small contracts. Is this the NHS unravelling? Well, if it is, it is unravelling slowly, and it began not under the coalition government, but under their Labour predecessors. The coalition government embraced Labour's direction enthusiastically, and the situation with respect to new contracts may lead to a continued expansion of private provision in the NHS. But it was Labour that made this expansion possible in the first place through their own changes in the 2000s. Are Labour responsible then? Yes, partially – they are responsible because they put in place changes that a Conservative government probably could not have got away with introducing straightforwardly.

But what about the public service ethos? Is not that what is dying under the coalition government? Is not it the case that, by becoming ever-more focused on contracts and private provision, what is really happening is that public services are becoming more private in their outlook, and the goodwill and distinctive service you get from the NHS will become compromised?

I think there is something important about this argument, but still, it is rather elusive. Let us remember that there have been regular problems with public service in the NHS, even when it was almost entirely publically provided and publically funded. The state of general practitioner (GP) surgeries in the 1950s was often dreadful, and the hospitals where the mentally ill were held in the 1950 and 1960s were often deplorable. More recently we have had the problems with children's services at Bristol Hospital, with serial-killing Harold Shipman, and of course, Mid-Staffordshire, and Morecambe Bay. Those are just the headlines – there are numerous other cases of care failure of one kind or another. Now, in an organisation as big as the NHS, mistakes are going to get made, and in healthcare, that may result in people getting hurt or even killed. But my point is that a publically-owned and funded healthcare system does not make those problems magically go away because of something called the public service ethos.

Equally, anyone with memories of hospital outpatient appointments system up to the 2000s will remember numerous people turning up and discovering they had the same timeslots – the assumption being that the consultant's time was more valuable than theirs and that they should have to wait. Medical sociology has shown us numerous examples of care practices which appear to have been introduced more because they suited healthcare professionals than benefited their patients. The public service ethos did not protect patients from these things happening, either.

But there is something to the public service ethos argument. First, as we noted above, we need a comprehensive provider of care of last resort. We have never dealt with the problem of what happens if a private provider of care exits the market. Another private provider is unlikely to be found at short notice, or perhaps at reasonable cost, and so it is imperative that public provision is able to fill the gap. And if it is necessary for public provision to be always available on these terms, then that substantially weakens the case for private provision being efficient or necessary at all as a competitor – at best it can be there to complement public provision. The public ethos here is that of availability, and with that, some element of comprehensiveness must remain. We need services to be guaranteed to be available.

The Current NHS Reorganization

Has the current health reorganization undermined this principle of availability? In some areas, and in some specialisms, there is a case that they have. Where public providers have wholly left certain specialisms in some geographic areas, which seems to have been the case, then it is not clear what happens if private providers fail or decide to leave. That has to be a potential problem for those living in the area. If health services fail because of nonavailability of care, then this represents the NHS having a wolf at the door.

Another problem might come in the form of what happens if staff, increasingly employed by private providers, come to be more motivated by extrinsic (external) rather than intrinsic (doing the job for its own sake) motivations. Something that is striking is the extent to which the NHS depends upon the goodwill of its staff – especially its clinical staff. If doctors and nurses and pharmacists, and all the other professionals in our healthcare system, were to work the hours they are actually contracted to do, the NHS would probably collapse overnight. But if staff come to view their work in increasingly contractarian terms, as may well be the case if they are increasingly working for private providers, and they become more motivated by pay than by the more vocational motivators of caring for people, then we might expect them to be less prepared to make the extra effort they presently go to. This is not speculation – research examining intrinsic motivation and how it can be 'crowded out' by extrinsic incentives, suggest there are good reasons for worrying about this.³ In a world in which markets are increasingly being used as the means of organising healthcare, that represents a second wolf that may be, if not at the door, then currently wondering around the back yard in a worrying kind of way. An NHS dominated by a contract-based ethos would be very different to the one we still have today.

None of the major political parties in England are suggesting there will be funding cuts, even if the NHS is having to deal with the implications of huge cuts to social care budgets in local government. Equally, the well-known pressures on health expenditures mean they often have to increase just to keep pace with medical technology, so that the appearance of 'ring-fencing' NHS budgets is probably just that, an appearance. However, we do have to recognise that the NHS is not under the same threat of budgetary reductions that other public services are.

So where are we then? Well, as in most eras (where Powell is

again right), the NHS is both doing 'business as usual,' and in crisis. Is it different this time? Will we only know for sure, to go back to Joni Mitchell 'when it is gone'? Well, it all depends on what you think the NHS is, and what it is for. My own view is that the extension of the privatisation of contracts, the budgetary pressures the service is under (which I have not touched on above), the increased need to work across health and social care boundaries (with social care being in an even worse state than the NHS in terms of its finances), and the bizarre ideology shared by both the main political parties, that markets are the way forward on any reorganisation, means that it *is* different now. If the NHS is distinctive, it is because of its very public model of healthcare, in terms of provision (and ownership *does* matter) and ethos, and that is at risk of being undermined. We might call this the 'public' model, and it is the public model of the NHS that is under assault on more fronts than ever before, and under more pressure. We will not know the day it finally collapses, and will have to look back to find it. But we will live to regret the day the public NHS finally

dies – and I hope by then it is not too late then to bring it back.

Ethical issues

Not applicable.

Competing interests

Author declares that he has no competing interests.

Author's contribution

IG is the single author of the manuscript.

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