Introduction

An inauguration usually marks a beginning. In my case it marks an end - or at least the beginning of an end - of a career focussed entirely on health, health service development and the NHS. I first joined the National Health Service (NHS) in 1964. At that time it appeared to me to be an entrenched part of the social fabric and yet it had been created only sixteen years earlier, in 1948. I learned later just how inspirational and revolutionary that initiative had been. Yet later I discovered how vulnerable it remains to the kind of prejudice, limited vision and self-interest which could have strangled it at birth.

I am most grateful to the University for the honour of my appointment as a Visiting Professor. It is a particular privilege to be speaking here in South Wales because of its association with Aneurin Bevan and the transformation of health care in the United Kingdom which began on 5 July 1948. The transfer of responsibility for health from the UK government to the devolved administrations in the UK, twelve years ago¹, has provided new opportunities for the Celtic nations - including Wales - to reclaim that initiative, an opportunity that I know is not being lost.

During the past forty-five years, I have had the opportunity to work with people from many countries who share my commitment to health and the improvement of health-care systems. This has included all parts of the UK, Europe, the developing world, the Nordic countries and the USA.

I happened to be in the USA last year when the ‘debate’ about President Obama’s health care reforms was at its height. Once again, I was struck by the primitiveness of an apparently advanced nation in relation to its health care policy. Despite spending more on health care than any other nation (16.2% of GDP) there are shockingly wide variations in health status and accessibility to appropriate services.²

Forty million Americans do not have sickness insurance. Twenty seven per cent of lower income families have no cover. In 2008, one million Americans lost their health insurance when they lost their jobs in the recession. Health insurance can be terminated when people become chronically ill or otherwise high risk. Women often pay higher premiums. The average ambulance response time in some rural states is eighty minutes.

Recent hysterical lobbying in the USA has exposed the self-interest of those who wish to preserve the status quo. The context of unrestrained consumerism is graphically illustrated by the clever promotion of ‘designer’ drugs through relentless advertising. You will recall that the NHS was misrepresented as a totalitarian system which employs secret “death panels” to decide who lives and who dies.

The future of the NHS is still in the balance. Whilst Scotland and Wales have now taken a different course, the NHS in England is still the victim of a chaotic process of so-called “reform” which appears to have lost its way. This process was launched, twenty years ago, on the concept of the ‘internal market’, a simplistic, ideologically driven and consumerist concept based on prejudice, somewhat primitive market economic theory and out-dated management thinking.

There is little sign, in this UK election year, of any intelligent political debate on the fundamental issues related to health and the NHS. I therefore felt it might be helpful, on this occasion, to share my personal reflections on some of the issues which have influenced the development of the NHS over the past sixty years and which, I believe, are likely to remain significant in the future. I have chosen to consider three interweaving themes: ideology, evidence and inspiration.

### Ideology

*“Without the aid of prejudice and custom, I should not be able to find my way across the room”*

*(William Hazlitt 1778-1830)*

The creation of the NHS might justifiably be claimed to have been inspired. Nevertheless, there was copious evidence of serious deficiencies of the previous inequitable patchwork of inadequate and inaccessible services. The experience of the second world war, and the pressing need for social reconstruction after it, demanded a radical re-think. The prevailing mood supported an ideological perspective grounded in social solidarity.

The NHS was part of a wider, post-war aspiration, expressed in the inspiring 1942 Beveridge report ⁴, to slay the ‘five giants’ of ‘want, disease, ignorance, squalor and idleness’. The founding principles of the NHS emphasised the values of inclusion, equity, equality, and accessibility to health care regardless of individual ability to pay. Later experience led to recognition of the additional values of effectiveness, efficiency, appropriateness and responsiveness ⁵.

The objectives of the 1946 NHS Act were ambitious, laying on a UK Government Minister a duty to:

*“promote the establishment of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and Wales and

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the prevention, diagnosis and treatment of illness, and for that purpose to provide or secure the effective provision of services......”

The 1946 Act illustrates what has been described, in the social policy literature, as an ‘institutionalist’ perspective. The institutionalist model is based on the belief that certain social institutions must be maintained and enhanced for individual and collective benefit. The model emphasises social solidarity and mutual dependence for mutual benefit.

The institutionalist model assumes that poverty and disadvantage are unlikely to be alleviated by economic markets and unreliable economic growth. Health is a fundamental human right which must be protected and enhanced for the benefit of all. Ill-health, for most people, is a certainty, not a risk, particularly as the population ages. The risks and expense are too high and unpredictable for individuals to bear and therefore must be shared. Health is an essential social investment enabling all individuals to achieve their potential. Economic growth depends on a healthy population. Health promotion, prevention of ill health and comprehensive health care services are therefore a social investment, not a cost.

A contrasting perspective has been described as ‘residualist’. This model postulates that increasing prosperity, achieved through economic growth, achieves gradual decline in poverty and dependence. Consequently, the need for state intervention and provision will progressively reduce. State funded, or provided, health services should therefore focus on the provision of a ‘safety net’ for the few who are unable to make their own provision in the market-place. The role of the State must be restricted to essential matters of public protection, such as the control of infectious disease. People must make their own choices about health care, and pay for them. This includes deciding whether or not to insure against ‘contingencies’ such as sickness. Services will develop appropriately in response to consumer demand and will improve through competition in the marketplace.

The ‘institutionalist’ perspective can today be seen most clearly in the healthcare systems of the Nordic countries which still emphasise social solidarity. Solidarity is similarly reflected, although in different ways, in the social insurance tradition of most of our European neighbours. The solidarity reflected in the healthcare systems of the former Soviet bloc has largely been displaced by more pluralistic and less adequate arrangements perceived (erroneously) to be the inevitable consequence of converting to a capitalist economy.

The institutionalist perspective also predominates in the work of the World Health Organisation (WHO) which advocates a “whole systems” approach to comprehensive health and health system planning including health promotion, strong primary care and integrated systems.

The 1999 Ljubljana declaration on ‘Improving Health Care’ indicated that health care reforms should be:

- Driven by values of human dignity, equity, solidarity and professional ethics;
- Targeted on protecting and promoting health;

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• Centred on people, allowing citizens to influence health services and take responsibility for their own health;

• Focussed on quality, including cost-effectiveness;

• Based on sustainable finances to allow universal coverage and equitable access, and

• Orientated towards primary health care.

The ‘residualist’ perspective is perhaps best illustrated by the USA. The US makes provision for disease control and seeks to influence some health behaviours. However, whilst providing minimalist safety nets, the health care system has largely been left to the market. Individuals (or their employers) have to decide which risks they can afford to insure against. Although the proposed Obama reforms have caused major domestic controversy, they are effectively only an extension of current sickness insurance, not a root and branch reform.

Whilst the philosophy of the NHS was clearly institutionalist in origin, the Service has been appropriately pragmatic in practice and has always embraced the concept of working with partners. For example, General Practitioners (GPs) have always been independent contractors and not employees. The contributions of voluntary organisations and private contractors have always been recognised.

However, the system has regularly faced challenges which have have prompted regular reviews. All of these (including the Guillebaud Committee in 1956 ⁹, the Royal Commission of 1979 ¹⁰ and the Wanless report of 2002 ¹¹ ) have consistently supported the fundamental principles of the NHS and and concluded that the most cost-effective way of providing health services in the UK is through a tax-funded, nationally organised and locally integrated system.

In office, whilst ideological blinkers have led them in different directions, politicians have repeatedly had to face the reality of demonstrable cost-effectiveness, the consistent popularity of the Service amongst users and voters and the commitment of those who work in it. As Pinker puts it:

“The ideological skeletons hang in separate cupboards but the political wind rattles both sets of bones”. ¹²

The political wind produced a remarkable political consensus on the development of the NHS during its first thirty five years. Following the Porritt report in 1962, ¹³ all political parties and health professions became united in the objective of integrating the previous three parts of the Service to improve the identification of health needs and the better planning and delivery of services: the only debate was about the detail of how best this might be done. ¹⁴ The major reorganisation of 1974, ¹⁵ intended to achieve this, was

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introduced in the dying days of a Conservative government, marginally modified by the incoming Labour Government and again tweaked by the Conservatives in 1982.

However, as in many other areas of social and economic policy, the consensus was shattered by the Thatcher government in the late 1980s. In accordance with its residualist tendencies, this government searched for ways of reducing the cost of the NHS to the public purse. Having failed to find a more cost-effective alternative to tax funding and public provision, it seized upon the almost casual observation of a visiting American academic. It decided (contrary to copious international evidence) that the introduction of competition between component parts of the NHS (and between the NHS and the private sector) would improve efficiency and reduce costs. The more fundamental concept of whole-system effectiveness and the lessons of history were disregarded. This decision was later described by a former member of the Thatcher cabinet as “a prime example of the subordination of its experience to its ideology.”

There were widespread expectations that the New Labour government, elected in 1997, would reverse this decision. The initial signs were promising. Early proposals for the local development of ‘Health Improvement Programmes’, accompanied by designation of ‘Health Action Zones’, appeared to indicate the re-introduction of needs-based planning. However, to the surprise of most observers, these initiatives were quickly abandoned in favour of further re-enforcement of the Conservative’s market approach.

Ironically, in England, whilst professing choice and a patient-centred service, the new government strengthened hospital provider dominance by abolishing Community Health Councils and introducing more independent ‘Foundation Trusts’, action aptly described by one contemporary commentator as “a totem pole for the future of the public sector when it is in reality yesterday’s answer to tomorrow’s world”. Wales wisely decided not to follow this route.

The counter to provider power and the voice for the customer was intended to be commissioning and competition. Commissioning never received the attention it required to stand any chance of success. Development was disabled by repeated reorganisation of health authorities and primary care trusts / health boards. It was originally assumed that only secondary, specialist services required commissioning, that GPs were in the best position to do this and that primary care did not need to be commissioned. Many GPs took a somewhat narrow, short-term view of specialist requirements and, with some notable exceptions, proved neither to be particularly effective commissioners, nor that interested in it. Sadly, some decisions influenced by these independent contractors cannot be seen to be entirely devoid of self-interest.

Later initiatives have focussed more on primary care but the tools have been of the expensive ‘carrot and stick’ type - such as competitive tendering and financial incentives - with limited effectiveness and some untoward consequences. The policy goals of these initiatives have not always been clear or consistent with the incentives offered to hospitals. Little sustained attention has been given to integration of the patient pathway across the boundary between primary and secondary care.

In England, the failure to learn the lessons of US commissioning was compounded by adoption of the kind of financial systems which have been shown, in the US and elsewhere, to inflate costs and activity. The latest system for funding English hospitals, whilst called “Payment by Results”, actually rewards hospitals for higher levels of activity with insufficient regard for appropriateness or quality of outcome.

This system, together with the kind of financial incentives offered to GPs, has probably been a factor influencing the apparently larger numbers of patients being admitted to hospitals in England compared to the rest of the UK. It is not possible to tell from the available data whether these admissions were clinically appropriate or how the outcomes compared with other parts of the UK. Ironically, in the respected ‘Health Maintenance Organisations’ (HMOs) in the USA, where integrated (or ‘managed’) care is better developed, in-patient admission is regarded as evidence of system failure.

Despite the failure of commissioning, some market enthusiasts want to push competition still further by introducing choice between commissioners. In addition to creating yet more confusion, fragmentation and bureaucracy, this would effectively mean adoption of most of the features of the US model. Unfortunately, sound advice from the US was not heeded.

In England, there is little evidence of the intended shift to primary care. ‘NHS Direct’ has been introduced but, overall, services appear to have become more specialist orientated. The concept of the ‘family’ doctor and continuity of care has been eroded. Some services have been privatized or duplicated. ‘Out-of-Hours’ services have been particularly criticised. It is difficult to refute the impression that GPs appear now to be paid more for doing less.

Little attention has been given by the current UK government to the development of a positive UK health strategy. Whilst the devolved administrations have moved this agenda forward, the 2000 ‘NHS Plan’ for England was a catalogue of additional expenditure on health services with little reference to intended outcomes. The absence of a strategy resulted in the UK government being shamed into action to ban smoking in public places, following initiatives taken in Scotland, Wales, Ireland and elsewhere.

After twenty years of the ‘internal market’ in the English NHS, the Service there is now fragmented, confused and inconsistently led. Whilst there have undoubtedly been some successes (such as the reduction of waiting times for elective surgery), many expensive central initiatives (for example, the NHS national IT programme) have failed. Most real improvements have been achieved by managerial action rather than competition.

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24 Toynbee. P. GPs who can’t manage should be brought back into the NHS....... The Guardian. Jan 19 2007.
26 For example, Improving Health in Wales (2001) and subsequent plans. Scotland produced Our National Health. (Scottish Executive, 2001) and subsequent papers.
Whilst there has been significant investment in new NHS buildings, these have been mortgaged to the private sector through the Private Finance Initiative (Public/Private Partnership). This will cost the NHS and the UK dear in the future. Resources have been wasted in duplication and expensive privatisation. New financial systems have created perverse incentives which emphasise quantity at the expense of quality. Overhead and transaction costs have increased.

The political rhetoric has been about competition and choice but political action has focussed on populist central direction and ‘top-down’ targets. The rhetoric of choice has concealed actual reduction of choice imposed by contracting. Local initiative has been eroded by inflexible central imperatives.

The plethora of targets and regulatory requirements, coupled with the threats of competition, have encouraged clinicians and managers to ‘play the system’. The inconsistency between regulatory assessment and the reality on the ground is gradually being exposed in a series of serious failures which do not enhance the credibility of the competing components of a proliferating regulatory regime.

The net impact of this incoherence is a cat’s cradle of inconsistent delegation, confused accountability, weakened public representation, hospital dominance, box-ticking regulation, bullying and low staff morale. The entire edifice has been built on a naive consumerist model without understanding of the determinants of health, the complexity of health care needs, the inter-dependence of the components of health care and the collective wisdom and experience of people at the sharp end.

The devolved administrations in Scotland and Wales were less inclined to follow the English route. They have now taken clear and positive steps to abolish the internal market and develop locally integrated services with an emphasis on prevention, primary care and a renewed institutionalist perspective. Northern Ireland is inclined to follow the same direction but its unique political situation inhibits progress.

Of course, political ideologies are not the only ideologies which influence the development of health care. Professional ideologies are at least as important. The most significant influence in the long-term are the professionals who work in the Service, particularly the doctors. However, patients do not lack influence. Patient pressure groups, frequently supported by professionals, stimulate the regular stream of media reports on alleged inadequacies of the NHS. Some of this has provoked knee-jerk political reaction. The issue is how best to channel and harness the experience and insights of patients into tangible quality improvement.

Professional perspectives do change over time. The stance of doctors is particularly interesting. There are long-standing differences of perspective between GPs and specialists which have shaped the service in the past and continue to shape it today. The British Medical Association (BMA) resisted the introduction of the NHS in 1948 (although not to the extent frequently portrayed). However, the BMA is currently leading the defence of the founding values of the NHS and challenging government policy, particularly in relation to privatisation.

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29 Pater J. E. op. cit.
30 Look After our NHS. bma.org.co.uk. See also: Politicians Need to Rethink the Role of the Private Sector in the NHS. Letters page. The Guardian 2 February 2010.
Collectively, NHS managers have sat on the fence. This is perhaps understandable in the culture of the English NHS which makes dissent a capital offence. Their commitment to evidence-based management practice is not particularly evident. Some have embraced the market philosophy. Others have been seduced by the private sector. Some have parroted the party line without really believing it. Many more have voted with their feet.

It is interesting that concerns of managers are now surfacing anonymously in health service magazines and straw polls. Although hardly scientific surveys, these indicate that, overall, most NHS managers do not support current UK government policy.

**Evidence**

Since I have ventured the opinion that current UK health policy is not entirely evidence-based, it may be helpful to say a little more about the subject of evidence.

I am not an admirer of Donald Rumsfeld. However, I am sure you will remember his statement about the Iraq war which was widely reported as evasive. He said:

“As we know, there are known knowns; there are things we know we know. We also know that there are known unknowns; that is to say we know there are some things we do not know. But there are also the unknown unknowns - the ones we don’t know we don’t know.”

I think this statement is rather profound - and self-evidently true. It might be a useful starting point for compiling a reference catalogue about what we know about what works best in health care, both at the individual clinical level and at the broader levels of health, policy, organisation and management.

I have already argued that Health and NHS policy have been unduly influenced for the past twenty years or so, by ideological prejudice. The views of elected representatives are valid, must be recognised and, in a democracy, ultimately prevail. However, since they are our representatives, politicians need to observe the opinions of more than a closed coterie of favourites. As Ham and others have argued, if politicians properly expect doctors and others to base their clinical and other decisions on valid evidence, it is not unreasonable to expect them to apply similar standards to themselves.

It seems that more recent policy has been unduly influenced by political advisers, particularly those from the chattering classes of South-Eastern England. Most have rather limited first-hand experience of health care or the NHS. Some have found their public profile a useful platform for career advancement. Some are academics who should better understand and observe the limits of their expertise.

The predominant source of advice appears to have been market enthusiasts who appear incapable of operating outside the box of somewhat primitive economic theory, the

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31 See, in particular, the Health Service Journal: HSJ.co.uk and nhsManagers.net.
conventional ‘production function’ and unsophisticated notions of ‘efficiency’, competition, motivation and consumer choice.

External observers frequently assume, wrongly, that hospitals are the focus of health care and that it is ‘efficient’ to increase the number of patients admitted per bed, to admit them more quickly and to increase the number of patients being seen by each doctor. This assumption also appears related to the delusion that the NHS is predominantly about straightforward elective surgery, despite the fact that most in-patient admissions are for other reasons, such as accidents, complex surgery, medical emergencies, mental health problems or having a baby.

Ninety per cent of all contacts with health professionals occur in the primary care sector. Most specialist care can now be be provided in an out-patient setting (including almost 70 per cent of elective surgery). Even leaving aside considerations of increased risk of infection and clinical errors, the assumption that hospital admission should be encouraged could not be more wrong.

Except in highly specific situations, the need for in-patient admission needs to be closely questioned. The HMOs in the USA are right to be concerned, on quality and cost-effectiveness grounds, about unnecessary admissions or prolonged length of stay.

Being in a hospital bed can be dangerous for all sorts of reasons. As one eminent hospital doctor, Richard Asher, put it in 1947:

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\begin{align*}
&\text{Teach us to live that we might dread} \\
&\text{Unnecessary time in bed.} \\
&\text{Get people up and we may save} \\
&\text{Our patients from an early grave.} \quad 36
\end{align*}
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Prevention and primary care are critical because most illness, in an aging population, is of a chronic or degenerative nature. Doctors need sufficient time and continuity with each patient to understand the complexity of the morbidity, to give them the best of their experience and to gain their trust. \(^{37}\) Patients benefit most from advice and support from highly trained and experienced experts who can work with them, unencumbered by anxieties about targets and financial incentives.

Patients also need time to make truly informed choices, based upon the best available evidence, provided by someone in whom they have confidence. This must include the option of non-intervention without fear of penalty - financial or otherwise - for the adviser for not seeing more patients or disposing of them more quickly. The only ultimate measures of success of any health care system are the outcome for the patient (whether they get better) and whole-system effectiveness (whether population health improves).

Market economists also seem to have a somewhat limited understanding of human motivation, assuming that people are primarily driven by self interest, particularly money. This ideology is reminiscent of discredited and paternalistic notions of management, such as that described, many years ago, by McGregor as ‘Theory X’. \(^{38}\)

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Managers of this school act on the assumption that the employees of an enterprise are constitutionally ill-disposed towards it and need to be coerced by threats, targets, competition and financial incentives, to ensure their commitment. Thus, NHS professionals, particularly doctors, need to be put in a competitive position with other professionals. They have to be closely watched to ensure they are not shirking. They need to have their ‘productivity’ closely managed and be offered the occasional bribe.

In contrast, McGregor’s ‘Theory Y’ describes a management philosophy that starts from the assumption that employees are intrinsically well disposed to support the success of the enterprise they have joined. McGregor, and scores of others, have conclusively demonstrated that leadership based on this kind of assumption is much more likely to gain commitment and achieve effective change.

A ‘Theory Y’ approach is likely to be more effective in most enterprises but managers in the NHS have a head start. Most NHS staff are highly motivated and hard-working. Although some occasionally confuse their own interests with those of patients, there is little shortage of commitment. Indeed, in my experience, the main challenge of NHS management is how to assess and respond to the continuous clamour for improvement within the reality of the available resources.

Some attitudes to doctors also appear to be influenced by outdated stereotypes; the ghost of Sir Lancelot Spratt 39 is still abroad! But these stereotypes are far from today’s reality.

At a more cerebral level, anxieties have undoubtedly been heightened by writers such as Illich whose 1975 polemic, ‘Medical Nemesis’ 40 describes the imperialistic ‘medicalisation’ of life by doctors conspiring to exploit patients for personal gain by peddling remedies of unproven, limited or negative efficacy.

Illich’s writings were a timely warning of medical interventions which might do more harm than good (so-called ‘iatrogenic’ disease) and the dangers of unrestrained professional power. However, Illich’s arguments are most credible in those societies (like the USA) where medical services are provided on a commercial basis. The overwhelming advantage of the NHS is (or was) that clinicians are free to act on their clinical judgement without extraneous corrupting influences or threats.

In the NHS context, doctors have responded positively to these accusations. Challenged both by Illich or, more cogently, by Archie Cochrane’s seminal work on ‘Effectiveness and Efficiency’, 41 the profession has made commendable and considerable effort to improve the evidence base.

Subsequently, most initiatives on ‘Evidence-based Medicine’ and related ‘Clinical Governance’ 42 have been taken by doctors themselves through their Royal Colleges.

39 Gordon R.  Doctor in the House and subsequent Carry-On films, 1954 onwards. James Robertson-Justice played the part of the eminent surgeon. See HSJ (2008 p75/6) for a further assessment of the impact of the media on public perceptions of health care and the NHS.


encouraged by leaders such as Cochrane, Donabedian, Berwick, Sackett and Gray. Some of these initiatives have also been influenced by writers on clinical risk, such as Vincent, and wider management thinking on ‘Total Quality Management’ as exemplified by writers such as Deming and Peters and Waterman.

New mechanisms have subsequently been established in the UK and elsewhere to undertake health technology assessment and to disseminate reliable information about clinical and cost-effectiveness, principally by undertaking ‘meta-analysis’ of earlier studies. These include the UK-based Cochrane Centre and the National Institute for Health and Clinical Excellence (NIHCE).

NIHCE was established to evaluate clinical interventions and determine whether they are sufficiently cost-effective to be supported by the NHS. This was an overdue initiative which is progressively filling an important information gap. Reports from NIHCE are almost guaranteed to secure publicity, particularly when it recommends that a new drug should not be adopted.

Although such evidence is essential to rational, evidence-based decision-making, there has been a debate about the definition of what constitutes evidence. A widely recognised definition of evidence-based medicine is:

“The conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.”

NIHCE acknowledges that the ‘Gold Standard’ for sound evidence in clinical practice is the double-blind, randomised, controlled clinical trial. However whether this kind of study is possible, ethically sound or, indeed, relevant in every clinical situation, remains controversial. This applies particularly to complex situations when the causes and progression of a condition may be multifactorial (for example, in mental health disorders). Furthermore, many clinical advances have been made incrementally by practitioners based on their experience. Their insights cannot be dismissed as merely ‘anecdotal’. Researchers do not have a monopoly on wisdom.

It has also been claimed that clinical research has failed to take account of the research methodologies and insights of other disciplines such as the social sciences. As Hunter has pointed out, “proper consideration needs to be given to experience, judgement, resources and values”. One might also add insight and intuition.

43 Donabedian A. Evaluating the Quality of Medical Care. Milbank Memorial Fund Quarterly. 1966: 44. 166-206.
50 Sackett DL et al. op cit.
There is also concern that NIHCE still appears to be over-focussed on single factors in a treatment programme, particularly the efficacy of a particular drug or treatment method. This runs contrary to the evidence that, in most clinical conditions, restoration of health depends on a complex variety of factors and influences, not least a well-managed treatment process and the attitude and understanding of the patient themselves. In this respect, NIHCE may not yet have taken sufficient account of insights gained from work on integrated care management and ‘health gain’.

Nevertheless, despite these criticisms, clinical professionals have taken a commendable leap in the development of evidence-based practice. Politicians might reflect on how they might do likewise but so should their advisers. Commitment to evidence-based management practice by some NHS managers may require further development.

So, returning to Rumsfeld’s dictum, what do we know about the key issues related to health and the best way of providing cost-effective health care? Here is a list of what I believe to be some of the “known knowns”. I will leave the “known unknowns” and the “unknown unknowns” for another occasion!

1. Health services are only one of the determinants of health. The others are inherited personal characteristics, all aspects of the environment and personal behaviour. Prevention is better than cure but it is not as exciting.

2. The patterns of ‘disease’ are changing. There are still significant environmental factors (including new threats from infectious disease). There are significant increases in those conditions which are related to personal behaviour such as accidents, smoking, casual sex, obesity and substance misuse (including alcohol). Chronic, degenerative and complex conditions are increasing as the population gets older. Iatrogenic conditions and clinical errors are a concern.

3. Resources are finite but costs of health services are increasing. The costs to the public purse are increasing as a proportion of total expenditure in all countries regardless of the type of health care system. Health cannot be bought. Health risks are effectively uninsurable.

4. The ethical dimension of health is becoming more problematic. The rights of the individual need to be balanced against the wider public interest. Needs, wants and demands are not the same thing. Every ill does not have a pill. Early intervention is critical in some conditions but not all.

5. The outcome of a health care experience depends on well-designed clinical processes and structures centred on the patient. The patient’s understanding, insights, trust and participation are critical to success.

6. Access to health care is best arranged through a well defined structure of primary, secondary and tertiary services and a supportive local and regional structure.

7. The way in which services are financed have an important influence on behaviour, appropriateness and quality. Care must be taken to avoid perverse incentives and unintended consequences.

8. Organisational and management arrangements have an indirect but critical impact on the quality of patient care. They must support the purpose of the system: form should follow function. Carefully designed integrated organisations at national, regional and local levels, promote the better assessment of need, deployment of resources and quality of services.

9. Evidence needs to be drawn from a variety of sources. A policy initiative can arise at any level of the system.

Inspiration

I applaud the painstaking work of those who are pursuing the quest for better evidence for clinical, policy and management decisions. However, there is a further factor: inspiration.

I said earlier that I was not a particular fan of Donald Rumsfeld: I am also somewhat agnostic about Mao Tse Tung. However, I gather that, like Rumsfeld, Mao also said something rather profound and relevant to those who aspire to lead effective change:

“Go to the common people and learn from them: then synthesise their experience into principles and theories: then return to the practical people and call upon them to put these principles and methods into practice so as to resolve their problems and achieve freedom and happiness.”

This was the philosophy of the medical pioneers. They did not have the luxury of retrospective or meta analysis of earlier work. They did not achieve change by looking backwards. If Harvey had done that he would not have discovered the circulation of blood.

The pioneers carefully observed the condition of ordinary people and acted on experience and intuition. They progressively tested their hunches, gathering widening circles of evidence. For example, Lister, a surgeon, strove to discover something which would reduce sepsis in surgery. Simpson, an obstetrician, developed early anaesthetics to ease the pain of childbirth.

The philosopher, Karl Popper has described this method of scientific endeavour as “hypothetico-deductivism” 57. He concluded that this is both a valid method of scientific enquiry and, being based on creative imagination, the most prevalent. This view is echoed by those who have researched the ways in which organisations develop and achieve successful change. For example, Lindblom 58 and others have described the value of “disjointed” or “guided” incrementalism in relation to planning and development.

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Frequently, the medical pioneers had the courage and conviction to test hunches by putting themselves in danger. For example, Jenner injected himself with live viruses in his search for a vaccine against smallpox. Marie Curie paid the price of her pioneering work on radiation by dying of leukaemia. Sometimes new discoveries were accidental although they depended on the inspiration of the experienced eye (for example, Fleming’s discovery of Penicillin). Some pioneers perceived needs well ahead of prevailing orthodoxy (for example, the humane treatment of the mentally ill).

The medical pioneers were complemented by those, such as Florence Nightingale and her less well-known nursing colleagues, who had the inspiration to see that outcomes could be improved by better management of the environment in which patients were treated. Other pioneers, such as John Snow, Edwin Chadwick and Robert Koch had the vision to improve public health.

The inspiration of individuals frequently evolved into initiatives by groups. Community organisations and volunteers were frequently critical engines for change. For example, for some reason, I always remember that the ‘Manchester and Salford Ladies Sanitary Reform League’ were the pioneers of health visiting! A significant proportion of social innovation has been stimulated by voluntary organisations (for example the ‘Samaritans’ or the hospice movement). Some movements were aided by royal patronage, for example, King Edward’s Hospital Fund for London.

Policy-makers have also made significant contributions to creating a better context for effective health care. In addition to the public figures such as Beveridge and Bevan, many unsung heroes made a contribution to the principles and organisational framework on which the NHS was originally based. These included Lord Dawson of Penn, Lord Moran, Wilson Jameson and John Maude. Many others have built on that foundation.

The 2008 Health Service Journal publication, ‘Sixty Years of the NHS’, brought back for me many memories of the heroes since 1948, many of whom I had the privilege to meet, particularly when I worked for the Kings Fund. Geoffrey Rivett’s assessment of the development of the NHS over fifty years, ‘Cradle to Grave’, is a more scholarly and powerful reminder of the range and volume of the contributions of many distinguished individuals and groups over many years.

I found it salutary to reflect on the many changes in the NHS that have occurred since I joined it in 1964. In 1960, women usually stayed in hospital for more than a week after childbirth. Maternal mortality was still significant. Hundreds of older people were warehoused in geriatric wards. The asylums still dominated mental health services. Suicide and abortion were criminal offences. Day surgery was virtually unknown. Minimally invasive surgery and organ transplantation had not been developed. Most children had their tonsils removed. There were no scanners. IVF was not available. Hip replacement and major joint surgery was unknown. Infectious diseases, such as TB and polio, were still significant scourges. Accident and Emergency services were patchy. The DNA helix had just been identified and no-one had dreamed of the possibilities of genetic engineering.

Advances were made on all of these fronts by clinicians and others, unassisted by political targets or incentive bonuses. The clinical and other leaders who led innovation are

59 Pater J. op. cit.
60 Health Service Journal. Sixty Years of the NHS. HSJ. 3 July 2008.

Some politicians provided critical leadership at key moments. Bevan comes immediately to mind but, at the other end of the political spectrum, Enoch Powell deserves credit for publishing, in 1962, the first national Hospital Plan on which our current pattern of general hospitals is based. Several Ministers steered the NHS to the more integrated structure introduced in 1974.

Civil Servants played a major but frequently hidden part. I particularly recall the contributions of George Godber, Cliff Graham and John Smith. Some external advisers and academics were also visionary or insightful. I am thinking of people like Teddy Chester, Richard Titmuss, Rudolf Klein, Edith Korner, Roy Griffiths and Brian Abel-Smith.

Let us not forget the inspiration of patients. Most clinicians will tell you how they have been inspired by the courage, suffering, humility and selflessness of ordinary people and their carers. I can remember being inspired by some of them myself. They include volunteers and the donors of organs and blood who literally give quietly of themselves for strangers, described, so movingly, in Titmuss’s seminal study, ‘The Gift Relationship’. Such selflessness puts self-centred consumerism into perspective.

The NHS requires high calibre leadership to pull together its vision for the future, to focus the clinical effort and to represent the Service to its political masters. I am proud to have worked with some of the best managers you could find anywhere. All had a real vocation to serve others in the best tradition of public service. Many were great communicators as well as distinguished leaders. Several made seminal contributions to the professional and academic literature. They understood the challenges required to manage ‘complex adaptive systems’.

In short, therefore, whilst I recognise the importance of ideology and applaud the invaluable contribution of better evidence, the evidence of history shows that most tangible improvements in health and health care are driven by the creative vision of committed clinicians, researchers, community activists, managers and politicians who have been inspired to improve health regardless of their political ideology. For them, the future of our health system was not an armchair intellectual exercise.

But the vision of individuals is influenced by the context in which they work. The collective efforts of the pioneers stimulated the creation of our valued social institutions such as hospitals, health centres, universities, the BBC and the NHS. Those institutions in turn have created the environment in which innovation and improvement can flourish.

It is interesting to speculate whether some of the innovations that we now take for granted might not have happened had the NHS not existed. It is beyond dispute that many who chose to work in the NHS have been inspired by the values and vision of the Service and

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the comradeship of shared endeavour. That commitment is threatened by prejudice, arrogance, misunderstanding and failure to learn the lessons of history.

I believe we need to reflect on those lessons to help us to define the kind of health service we want for the future and the values and evidence on which it is going to be based. As Chairman Mao implied, we need structures, processes and networks which harness the creative endeavour of all those “practical people” who can contribute to that vision.

**Conclusion**

Ideology, evidence and inspiration have all played their part in shaping health policy and services across the UK and are certain to continue to be important factors in the future. During the past twenty years, residualist ideology, free market economics, consumerism and prejudice have been predominant. Ideologies have an important place in social development but they require the discipline of constant challenge by the evidence, both of history and of what actually can be shown to work best.

Evidence is beginning to play a greater part. ‘Evidence-based medicine’ is securely embedded amongst doctors and other clinicians. We need to strengthen and broaden this initiative. But we also need to address serious deficiencies in the structured use of evidence in policy-making and its application in management practice.

The contribution of inspiration is less visible but no less important. Its value and influence has been insufficiently understood and seriously understated. Inspiration linked to altruism stimulates creative enquiry, careful observation and appropriate action. Inspiration, coupled with integrity, evidence, commitment and willingness to listen, are critical components of leadership. Inspiration contributed to the creation and development of the NHS. In turn, the NHS continues to inspire. It is essential to its survival that it should continue to do so.

The NHS is at a crossroads. Whilst it may not be unreasonable for the nations of the UK to pursue different directions, those paths are currently laid on fundamentally different ideologies. We need to understand the implications of this. This is particularly important in the smaller nations because of the potential dominance of the English and UK philosophy. We also need to consider the future of the NHS in a European and worldwide context. The most fundamental question is whether there will be an NHS, as we have known it, across the UK and, if this concept survives, whether it will be based on an institutionalist or residualist philosophy.

Residualism reinforces the subservience of social and health policy to economic policy. It promotes individualism and self-interest but denies the complexity of the determinants of health and the reality of mutual dependence. Market competition can reward and encourage enterprise but this is primarily motivated by self interest, not altruism. This can benefit those with the means and capacity to choose but it leads to inequality and deprivation. This denies life chances to the disadvantaged and future generations.

Institutionalism is more cost-effective and efficient in relation to health. It provides the infrastructure for health protection and the improvement of health status. It also promotes social cohesion and identity. It ensures more equitable access to treatment, both geographically and socially, at the time of need, free of financial anxiety for the individual and at lower cost to society. It enables needs to be assessed and priorities allocated.
Short-comings and ethical dilemmas are more readily highlighted and addressed. These include the much debated issues related to resources, rationing, iatrogenic conditions, performance and unsatisfied demand. Innovation is encouraged through professional networks. Mutual trust between patient and professional adviser is enabled. However, effort is required to distinguish professional and patient interests and ensure that patient and community needs really are paramount.

The direction in Scotland and Wales is now clearly institutionalist. That direction is backed by a substantial amount of evidence. Renewed attention is being given to community, social solidarity, prevention, primary care and professional relationships founded on trust. England is still heading in a residualist direction in a vehicle powered by market economics and consumerism.

The history of the NHS shows us how people of widely divergent ideological backgrounds were prepared to come together to work for the common good. Like our forefathers, I believe that we now need, at national, UK and European levels, to re-establish an open and honest debate about what kind of future we want for our health and health services, the values on which they should be based and how we can best get there. A debate about the ‘known knowns’ and the ‘known unknowns’ might be a useful start.

Political decision-making, particularly at the UK level, is ripe for review. In a modern democracy, ‘prejudice and custom’ are no justification for ignoring clear and well-founded evidence. The NHS and other important UK institutions are too important to be subjected to the whims and prejudice of individual Ministers (or the Prime Minister).

The history of decision-making in relation to the NHS during the past twenty years is a sad reflection on the British political process and machinery of government. This malaise is reflected in other areas of government decision-making and appears to require some radical solutions.

A particular concern is secretiveness, ‘spin’, dogmatism and the undue influence of political advisers. Advisers’ opinions need to be much more exposed to challenge from a wider range of relevant experience including civil servants, professional experts, front-line practitioners and others whose counsel can be shown to be more balanced and informed.

The architects of the 1946 Act had the wisdom to install some checks and balances. A central feature of the original structure was the UK Central Health Services Council which brought together various professional and other interests to advise the government. It provided a valuable bridge between various health interests, encouraged development, sponsored many research studies and made a significant contribution to health policy and practice. It was culled as a ‘Quango’ by the Thatcher government in 1980.

The Welsh Assembly Government has wisely begun to re-establish a more structured and inclusive approach to policy development. The new National Advisory Board for the NHS in Wales and other new structures are an important step in that direction.65 66 But, this is only a beginning. Sustaining a more inclusive and evidence-based direction will require determination, courage, commitment and a willingness to learn.

As Wales and the rest of the UK move forward in shaping health and NHS policy for the future, I believe that it may be helpful to bear in mind the wisdom of Peter Drucker. He said:

“Planning is not about trying to forecast the future. It means addressing the problems of today so that you deserve a future.”

DMH. 9 March 2010

davidmhands@hotmail.com

Tel: 01492 572997

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