

VIEWS & REVIEWS

PERSONAL VIEW

Does anyone understand the government's plan for the NHS?

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I was not looking forward to January. Each year I teach a course on health systems. My students are among the brightest and best of their generation. They come to London each year from more than 100 countries in a search for enlightenment about health and health policy. Last year the hot topic for discussion was the reorganisation of the US health system, led by President Obama. Although it required a few days of intensive reading, it was not difficult to explain. The justification for change was clear. There was a health system that was the most expensive in the world yet left over 40 million US residents without cover, and which, as we had shown in our research on avoidable mortality (*Health Affairs* 2008;27:58-71), was making almost no progress in improving health outcomes. The proposals were relatively straightforward to understand. It was essentially what is called “pay or play,” whereby any person not covered by an employer sponsored health plan or other public insurance must purchase health coverage or be penalised financially. It had a number of weaknesses, such as a failure to cover undocumented migrants and inadequate mechanisms for cost control, but these could be understood given the complex, but clearly defined, legislative process that had to be navigated through Congress and the need to placate strong vested interests.

This year it is different. I know my students will expect me to explain the changes proposed by the Department of Health in England. If I am to do so, I need to understand them first. Here lies the problem. No matter how hard I try, I can't—despite 25 years of experience researching health systems, including writing over 30 books and 500 academic papers.

My first problem is understanding the problem the changes are trying to solve. The government argues that reform is needed because the NHS is performing so badly in international terms. Yet the evidence it has produced, such as deaths from heart attacks, has been totally discredited (*BMJ* 2011;342:d566) and one independent source after another, from the Commonwealth Fund in the United States to the Organisation for Economic Co-operation and Development (OECD), has produced reports showing that while the UK once lagged behind other countries, when the amount of money spent on it was among the lowest of any industrialised country, it is now improving at a faster

rate than almost anywhere else (Gay JG et al. OECD, 2011). This is confirmed by our own work, again using avoidable mortality, which the Department of Health has now adopted as its own high level indicator of health system performance. What's more, on many indicators, such as coordination of care, the NHS outperforms all the rest. Crucially, the OECD has argued that the UK would have done even better if it had not continually been reorganising the NHS (www.guardian.co.uk/politics/2011/nov/23/health-bill-nhs-oecd-report).

My second problem is to understand what is being proposed. I can take some consolation from Malcolm Grant, the incoming chairman of the National Commissioning Board, himself a distinguished academic, who has described the bill as “completely unintelligible” (www.guardian.co.uk/society/2011/oct/19/nhs-reform-bill-completely-unintelligible), but surely there must be someone somewhere who understands it? After all, the secretary of state for health consistently tells those of us who think we have spotted problems that this is simply because we don't understand it. I have tried very hard, as have some of my cleverer colleagues, but no matter how hard we try, we always end up concluding that the bill means something quite different from what the secretary of state says it does.

Take privatisation. No less a figure than the prime minister has reassured us that he will not privatise the NHS. Yet the management of one hospital has just been handed over to what is essentially a private equity consortium, even though it is misleadingly dressed up to look like a social enterprise. And the latest guidance makes clear that commissioning will be done not by general practitioners but by private companies, who are required to increase the number of patients treated in private facilities. Then there is the secretary of state's role. I read that he will no longer have a direct role in the management of the NHS but every time I open this journal I read of ever more examples, from waiting times to refusals to treatments, where he is actively intervening.

My third problem is understanding why so much is happening now. I know this will be a particular problem when I try to explain things to my American students, who have a clear understanding of the concept of the separation of powers

between the executive, legislature, and judiciary. The US president, like his counterparts in most advanced democracies, cannot do anything without the approval of the legislature. Indeed, on a few occasions in recent decades, the operations of the US government have come close to grinding to a halt as Congress delays agreeing a budget. Yet, here, the Health and Social Care Bill 2011 is already being implemented even though it has not passed into law. Indeed, the government's main justification for passing the bill now seems to be that the bill is already being implemented and it is impossible to go back. How will I explain to my students that this is not contempt of parliament?

I realise that my bewilderment may simply be a consequence of my own failure to understand the insights that have been granted to wiser and more learned individuals than myself. After all, many readers of this journal are actively implementing government policy, so they must understand what they are trying to do and the legal basis for doing it. I worked hard over the

Christmas break so that I might be in a position to understand these three puzzles. But I'm also hoping that someone, somewhere, among the *BMJ*'s extensive and erudite readership, will be able to help me.

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