Restoring Our Better NHS:

abolishing marketised commissioning is an essential start

but is not nearly enough

David Zigmond

The government's long parried acknowledgement of the unviability of many years' NHS reforms will be welcomed by almost all its healthcare staff. But this proposed reform-of-reforms appears to overlook many of our recently accrued problems. What are these?

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At last this citadel – that of successive governments' commercially modelled NHS reforms – seems now to be crumbling.

At the beginning of February, the news briefly headlined a leaked government White Paper proposing major NHS reforms. Five days later the Health Secretary indicated the correctness of these reports. Central to the proposals is the abolition of the purchaser–provider split, with its complex and cumbersomely contentious marketised commissioning. If this White Paper leads to these recommendations, that will surely be an important first step toward restoring the more viable and less fractious NHS that many have been long campaigning for.

But any celebration of this needs caution: there are other, equally important, recent developments that need rescinding yet remain largely unacknowledged in this report. Here is a brief, yet larger, overview.

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First the recommendations.

For thirty years successive governments cleaved to the mistaken notion that best healthcare was best assured by 'market discipline'; this was zealously amplified by Lansley's 2012 Health and Social Care Act. Yet for these three decades the government had mounting feedback from practitioners, researchers and patients about the speciousness of these reforms – rather than getting 'market discipline' we

were getting, instead, not just market mendacity and expedience, but then the kind of anomie, human heedlessness and mistrust that can come from the worst kind of corporate commercialism.

It became increasingly recognised that the competitive marketisation of our NHS is divisive and erosive of trust, rapport and care. It is widely implicated in our growing crisis of professional staff retention. It has magnified the gap between health and social care. So the government may be tempted to think that merely rescinding such marketisation will be sufficient to reintegrate those Welfare services that have become so fragmented and dispirited. Consequently there is much talk of restorative 'Integrated Care Services', themselves serviced by 'Primary Care Networks' – enormous conglomerates of flexibly deployed GPs.

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What about the oversights?

Well, such hopeful initiatives will still be stymied by two other legacies of our thirty years of reforms: the reforming programmes of *giantism* (eg increasingly large, centralised and remote hospitals, GP surgeries, etc) and *coercive bureaucracy* (remote regimes of management, inspection and compliance: REMIC). These two have been developed as expedient cohorts to the commercially industrialised healthcare that has so divided and estranged colleagues; all have combined to lose our better human contact with patients.

Any potential major reform should first recognise, and then prioritise, that much of our better healthcare depends upon personal understanding, trust and bonds. These can only grow if practitioners have the necessary headspace and heartspace to invest not just in their patients, but also in their colleagues. Such inter-professional dialogue and care thus works best in smaller units with stable, personally familiar working teams where healthcarers get to know one another and their patients: professional communities serving communities of those in need. This was the strength of our better pre-serially-reformed NHS.

Indeed, the erstwhile vocationally motivated smaller GP surgery, and the hospital consultant-led firm, could more easily provide such 'integrated care' because it was a natural extension of their personally informed and performed practice: 'integration' is much easier when we know who we are dealing with, whether they are patients or other professionals.

Can we provide humanly sensitive and intelligent care, instead, by the now vaunted systems of algorithms and procedures instructing professionals who are still subordinated to vast institutions that have neither the time nor the proximity to get to know the people they must care for and work with?

This is a cardinal question that this White Paper seems not to heed.

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