The NHS Internal Market

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Professor Marshall Marinker, Foundation Professor of General Practice and Head, Department of Community Health, University of Leicester (1974-1982); Director, MSD Foundation (1982-1992)

Dr John Marks, GP (1954-1990); Member of Standing Medical Advisory Committee (1984-1990) and Chairman, British Medical Association Council (1984-1990)

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Introduction

Margaret Thatcher's announcement on the BBC *Panorama* programme on 25 January 1988 that the National Health Service (NHS) was to be reformed was a surprise to the Department of Health (DH), and to service workers. The reforms that ensued – often referred to as the introduction of the 'internal market' – radically changed NHS principles, culture and processes. This witness seminar examines the origins of the reform, its implementation and consequences.

A perfect storm of restricted funding, growing demand for health care services and rationing (e.g. cancellations of operations, closures of wards) had precipitated the Prime Minister's announcement in January 1988. But until the publication of the 1989 White Paper *Working for Patients*, which foreshadowed the 1990 NHS and Community Care Act, economic concepts such as markets, competition or purchaser-provider splits were rarely discussed as solutions amongst the mainstream policy community. The problem of the rising cost of the health service was not a new one. The 1956 Guillebaud Report into the Cost of the National Health Service had concluded that the early service was sustainable but would require additional funding.[1] From the 1960s, there had been attempts from the margins, for instance by think-tanks such as the Institute of Economic Affairs, to begin a debate about privatising the NHS or introducing health care vouchers as trialled in the United States. But for over three decades, despite adjustments to the types of services covered by the principle of universal health care, there was no radical attempt to reform how the UK's health system was financed.

In 1981, an inter-departmental working party on alternative means of financing health care was created by ministers and marked a first step in Government reflection about how the service was financed. Throughout the 1980s, a number of DH groups formed of administrators, government analysts and academic economists were constituted, and individual civil servants were sent to the United States and Canada, to report on recent reforms. Ideas central to the internal market reforms were also being formulated by academics and practitioners. The UK economist Alan Maynard began formulating his general practitioner [GP] fundholding proposals in the mid-1980s, through which GPs could be financially incentivised to reduce cost. Marshall Marinker, a GP and academic, was also stimulating debate on how to pay for healthcare. The issue of cross-boundary patient flows crystallised as a critical issue, leading to a number of local pilot schemes.

In 1983, the Nuffield Trust commissioned Professor Alain Enthoven, a US economist, to study the NHS, which was published in 1985 as *Reflections on the Management of the National Health Service*.[2] Enthoven put forward ideas of managed competition to incentivise NHS stakeholders in order to improve efficiency and responsiveness to patient needs. His presence and visibility in the UK appears to have been significant in the move towards a radical NHS reform. Within the DH, a number of initiatives such as the NHS Performance Indicators project in the mid-1980s and a succession of information systems reviews and projects, such as the 1982 Körner Review on Health Services Information, helped bolster the idea of improving efficiency in health care, and prepared the terrain for the 1989 reforms.[3]

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[1] The Guillebaud Committee into the Cost of the National Health Service was formed in 1953, chaired by Claude Guillebaud, a Professor of Economics at Cambridge. The Committee reported in 1956, concluding that the NHS was financially sustainable but would require extra funding in the future.

[2] Enthoven, A. (1985), *Reflections on the Management of the National Health Service*, London: NPHT.

[3] Körner, E. (1982), *First Report of the Steering Group on Health Services Information*, London: HMSO.

The process of the 1991 reform was very different to that of the earlier NHS reforms, such as the large-scale reorganisation of 1974. Three points were key. First, a secret working group under the direction of the Prime Minister was established, and included close allies such as David Willetts (Director of Studies, Centre for Policy Studies, 1987-1992), Nigel Lawson (Chancellor of the Exchequer, 1983-1989) and John Major (Chief Secretary to the Treasury, 1987-1989). Second, for the first time in the history of the NHS, traditional stakeholders – the Royal medical colleges, British Medical Association, and official NHS bodies – were not consulted. Third, the reform was rapidly implemented from April 1991 without any meaningful pilot study.

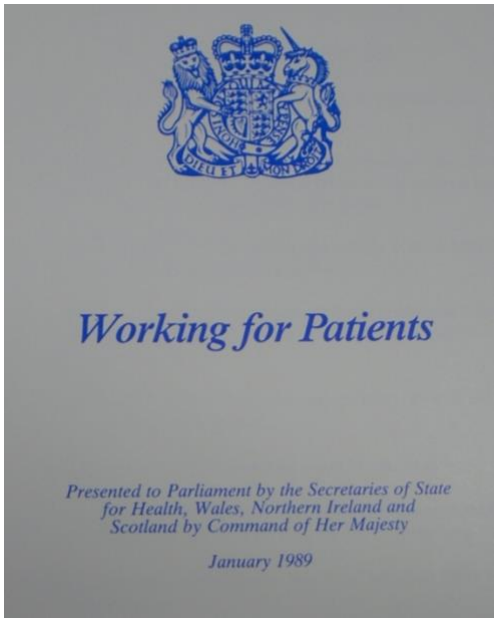

Image 1: Front cover of the White Paper on Health Services *Working for Patients*.

The reform had three central components. First, purchasers and providers were 'split'. District health authorities (DHAs) became the main purchasers, receiving government funding based on their population's calculated needs. DHAs could buy goods and services from any provider, be they from public, private or voluntary organisations. Second, NHS trusts, outside DHAs' control, were created from acute hospitals and other providers. These new trusts – also known as 'self-governing hospitals' – became the DHAs' providers. They had to offer the best price and quality to win contracts, failure leading to closure. Third, GP practices were offered the opportunity to have their own budgets for non-emergency care – known as 'fundholding'. The money now followed the patient with fundholders being able to keep profits generated in the process to improve practices (similarly to clinical budgeting in the 1980s).

The internal market reforms had far-reaching but mixed consequences for the NHS. On the one hand, evaluations by economists suggest that productivity increased and that the costs of hospital care were reduced.[4] On the other, it can be argued that the majority of services continued to be delivered in the traditional format, that management costs – notably to supervise the purchasing and providing of services – markedly increased, and that the quality of health care services may actually have suffered from the increased competition.[5] The Labour government elected in May 1997 initially envisaged the end of marketization in the health service, having campaigned on this issue. Eventually however, it introduced further market-type initiatives, notably around performance and commissioning.

[4] Mays, N.; Dixon, A. and Jones, L. (2011), *Understanding New Labour's market reforms*. Kings Fund, London.

[5] Propper, C.; Burgess, S. and Gossage, D. (2003), *Competition and Quality: Evidence from the NHS Internal Market 1991-1999*, CMPO Working Paper Series No. 03/077.

Areas for discussion

1. Origins of the reform
    a. What role did the British context of rising costs and growing demand for health care play in Margaret Thatcher's 1988 announcement of the NHS review?
    b. How influential were international examples such as the US health care reforms in the UK?
    c. How did the 1981 inter-departmental review on alternative health finance come about and why did it fail?
    d. How did the growth of economic ideas in health – or health economics – prepare the terrain for discussing ideas of costs, inputs and outputs and quality?

2. Formulation of the reform
    a. How was Margaret Thatcher's announcement on *Panorama* received?
    b. What role did the Prime Minister's 'secret group' play in the formulation of the reform and how did it interact with other players such as the Department of Health?
    c. Who were the stakeholders involved in the DH review group?
    d. What role did economists play in and outside government during the formulation?
    e. Why were traditional stakeholders such as the royal medical colleges and the BMA not consulted?
    f. How radical was *Working for Patients*?

3. Implementation of the reform
    a. Why were there no pilot studies and what was the impact of this decision?
    b. How important were the different projects put in place to implement the reform?
    c. What role did various organisations play in the rolling-out of the reform? E.g. DH, NHS Management Executive, professional organisations?
    d. What issues were encountered and how were they dealt with?
    e. How were different NHS groups 'won over' by the reform? E.g. NHS managers, clinical staff?

4. The legacy
    a. Did the reform improve the NHS; if yes, how?
    b. Did the reform achieve its goals of quality, transparency of information, responsiveness, money following the patient, and value for money?
    c. Were some consequences of the reform unforeseen?
    d. Should competition have been rolled out more widely rather than 'managed'?
    e. What lessons can be learnt from the 1991 Internal Market reforms?

Witness Seminar Transcript: The NHS Internal Market

Professor Sally Sheard

I welcome you all to the University of Liverpool in London and to this witness seminar on the 1991 NHS internal market. I am very grateful: we have ten enormously significant individuals here who were involved in the planning, organisation, or the implementation of the 1991 internal market. I have to thank, as well, the Wellcome Trust who are funding this event through my five-year Wellcome Trust project. This project is looking at the governance of health in Britain and the role of different types of expertise – medical expertise, economic expertise and managerial expertise – and how that has changed since the formation of the NHS in 1948.

We held a witness seminar last year on the 1974 NHS reorganisation, and that produced some very interesting results around the role of management-consultant firms such as McKinsey's, the speed with which that reorganisation happened, and the fact that, within two years, a Royal Commission on the NHS had to be established. It was the first of more than 20 reforms of the NHS that have happened subsequently. We have been in a series of relentless reforms, really.

This witness seminar focuses on 1991. We also want to consider the evidence for what had happened in the previous decade, the role of health economists, medical professionals and management-consultant firms, as well as what counted as expertise in 1991: who valued expertise and who was looking for expertise on reforms.

I need to also give some apologies. We were hoping to have Alain Enthoven join us by Skype;

Image 2: (Left to right) Nick Bosanquet, John James, Kenneth Clarke, Nick Timmins, Graham Hart, Strachan Heppell, Sally Sheard and Marshall Marinker

unfortunately, he is indisposed, but he has sent us a written statement, and Nick is going to draw on that. We also have apologies from Alan Maynard, Geoffrey Rivett, Walter Holland, Robert Maxwell,

Andrew Burchell and Ian Mills, but I am delighted that we also have two additional guests who we did not expect to be here: Sir Terence English, who was president of the Royal College of Surgeons between 1989 and 1992; and, hopefully later, Jeremy Hurst will join as well, who was a significant civil servant in the course of these reforms.

Some of you will be familiar with the witness-seminar format: bringing people together to discuss a particular policy, crisis or episode; the idea that shared views are cumulatively more important and valuable than individual oral histories. There will be tensions and diversions over the course of the next few hours as we talk through the issues.

Nick Timmins is very kindly chairing this again for us. Nick is now an expert at chairing witness seminars. Nick is going to take us through, chronologically, the questions that we would like to address and call on the witnesses in turn. He will also give the audience opportunities to participate as well, so we hope that there will be contributions coming from you, and questions from you to the witnesses sitting in front of you. I am going to pass over now to Nick and look forward to an interesting afternoon. Thank you.

Nicholas Timmins

Thanks a lot, Sally – it is great to see you all here. I apologise for the classroom layout, which makes it quite difficult to see you all. If you want to intervene and I am not noticing, just wave your hand ever more furiously. We are going to do this in four sections: we are going to do the origins of the 1991 reforms and their formulation – two 40-minute sections. Then we will have a break for a cup of tea before doing implementation and the legacy.

We are going to start a little further back than the row that led to the reform in the first place, with a 1981 look at alternative finance for the NHS.[6] Unless I am mistaken, I do not think anyone here was directly involved in it, but Patrick Jenkin set it up after being goaded by some of the right-wing think-tanks like the Adam Smith Institute and the Centre for Policy Studies for being a wimp. [7] [8] [9] It looked at alternative financing and produced an interim report, complete with advisors from Bupa and what have you, which came to no very particular conclusion.[10] It was sitting there when Norman Fowler arrived in 1982, and you arrived very shortly afterwards.[11]

[6] In 1981, an inter-departmental working party on alternative means of financing health care was created to consider alternatives to tax-based funding, notably private health care and social insurance. The findings of this working party were not followed up. See Smee, C. (2005), *Speaking Truth to Power: Two Decades of Analysis in the Department of Health*, Oxford: Nuffield Trust. The National Archives (TNA), T 477/45, 46, and 85, *Financing the National Health Service (NHS): Interdepartmental Working Party on Alternative Means of Financing Health Care* (1981-1982); MH 170/351, *National Health Service costs: Report of the Inter-departmental Working Party on Alternative Means of Financing Health Care* (1981-1982).

[7] Patrick Jenkin (1926-2016) was a Conservative politician and Secretary of State for Health and Social Services (1979-1981).

[8] The Adam Smith Institute is a British neoliberal think-tank created in 1977.

[9] The Centre for Policy Studies is a British free-market think-tank created in 1974 by Keith Joseph and Margaret Thatcher.

[10] Bupa, or the British United Provident Association, is a private healthcare conglomerate created in 1947 which provides healthcare insurance as well as owns healthcare facilities such as hospitals in the UK and abroad.

[11] Norman Fowler was Secretary of State for Health and Social Services 1981-1987).

Kenneth Clarke

Yes, I followed him from the Department for Transport. He could not get on with Gerard Vaughan [laughter] and he persuaded Margaret [Thatcher] to send me over as Minister of State. [12] [13]

Nicholas Timmins

Yes, and Norman just buried it.

Kenneth Clarke

Yes, we both thought it was mad [laughter]. Firstly, it was abandoning some of the best features of the health service, accepting lobbying from right-wing members of the party with whom neither of us agreed and who continue, to this day, to argue that the NHS is fundamentally flawed and that the answer to running the health service is to give in to all the lobbies – particularly the noisy ones – and to give them more money. They argue that, as you do not want to raise that from taxation, you have to find some alternative way of financing the National Health Service. Variants of that come round every so often.

Image 3: Kenneth Clarke

This particular version, as you say, was not even very well-written, and my recollection is that it was just flatly refused and ditched. Apart from the desirability of it, the politics of it would have been suicidal. We were a deeply unpopular government. The Labour Party had split into two. Both halves of it were miles ahead of us in the opinion polls [laughter]. We were very engaged in some very important economic reforms but all our policies were extremely unpopular. To put into the middle of this mix that we were going [to], nowadays people would say, privatise the NHS, would have put the tin lid on everything, so it was therefore bumped off very rapidly.

Nicholas Timmins

From that, we get into the run-up to what led to the famous magic moment on *Panorama*, when Margaret Thatcher announced that there was an NHS review underway.[14] My view is that what essentially drove that was the money, because, as you and Norman [Fowler] took over, what had been a relatively generous settlement made by Labour as it left, to which the Conservatives stuck, ended and the money was getting tighter and tighter.

[12] Gerard Vaughan (1923-2003) was a consultant at Guy's Hospital (1958-1979) and Minister for Health, DHSS (1979-1982).

[13] Margaret Thatcher (1925-2013) was Prime Minister of the United Kingdom (1979-1990). She oversaw the introduction of general management in the NHS in 1983 and the creation of the NHS internal market in 1991.

[14] Margaret Thatcher's announcement on the BBC *Panorama* programme on 25 January 1988 that the National Health Service (NHS) was to be reformed was a surprise to the Department of Health (DH), and to service workers.

Kenneth Clarke

The politics of the time was consumed by arguments about cuts, as it always is, but the cuts to the National Health Service were the most sensitive. Margaret, who had been frustrated in the way that we have just described, found that, week after week, she was facing questions about NHS cuts and trying to answer them, as people still do, with reams of statistics about how many more people we were treating – *tout ça change*. If you watch it tomorrow [televised parliamentary debate] and if they can talk about anything other than Brexit, it will be lots of things about how many more nurses we have.

This was getting her nowhere and, again, she thought that the whole thing was fundamentally flawed. It was a sudden, dramatic decision, I think, rather like David Cameron deciding that he would solve the European issue by calling a referendum [laughter]. She announced that it was going to be reformed – a fundamental reform – just to move on. She was convinced that, somehow, it needed to be changed fundamentally. I did not come along until later – I just observed all this happening – and I do not think she ever quite worked out what reform she had in mind, but that it must be reformed and she announced it. It was just a statement – there was no substance to it when she announced it.

Nicholas Timmins

At the very beginning, I should have said who is on the platform, so I will do that. Marshall Marinker on my far left, who was with the MSD Foundation at the time. He was a GP doing all sorts of research around things. Strachan Heppell, who, when this review got going, ran it. Graham Hart, who, at the time, was Director of Operations on the NHS Management Board because the Griffiths reforms had come in on the way here. There is Ken [Clarke]. John James, who was Finance Director in the Department of Health at the time. Nick Bosanquet, who, along with Alan Maynard and others, was involved with stirring ideas about how we make changes in the financial incentives and the way the NHS worked.[15]

John: the money?

John James

Can I pick up a couple of other questions that have been bypassed? The reason why the Alain Enthoven report was turned down is that my predecessor, a lady called Terri Banks, who read it and wrote an appraisal of it. [16] [17] She said there were some very good ideas in it but that, to implement it, you would need to have completed the process of ensuring that all health authorities had their fair share of the resources. That was what knocked it. That became an issue later, when we were thinking about how we could implement the changes that Ken oversaw.

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[15] Strachan Heppell later added: 'It is worth adding that once a reform process is under way within Government, ideas and proposals are subject to continuous challenge and debate. Ideas that have originated outside – or for that matter, inside - Government rarely emerge unscathed and unaltered. It is an organic process with many contributors. Identifying any one person for originating a particular reform does not make much sense in this context.'

[16] Alain Enthoven is Marriner S. Eccles Professor of Public and Private Management at Stanford University. His work on health informed the 1970s US reforms which created Health Maintenance Organisations (HMOs), organisations combining health care financing and delivery. It also informed the 1989-1991 British health reforms. Enthoven, A. (1985), *Reflections on the Management of the National Health Service*, London: NPHT.

[17] Terri Banks was Assistant Principal, Colonial Office, 1955-66. Principal, Treasury, 1966-72; Assistant Secretary, 1972-81, Under Secretary, 1981-85, Director, Health Authority Finance, 1985-86, DHSS; Director, Office of Population and Censuses Surveys and Registrar General for England and Wales, 1986-1990.

I was appointed her successor at the very end of 1986, and the public expenditure round, the outcome of which led directly to all of this, was my first in charge. Boy, I did not enjoy the process [laughter]. I should say that I had been number two on the support for that but I had never been into the negotiations with the Chief Secretary. We put together our case in the usual way. A standard process was going on. Every department had to put its bids in by a certain date, which would be refined and discussed with officials and then eventually go in the autumn for discussion between ministers.

We were heavily influenced in constructing the bid by the clear evidence that a lot of health authorities felt that, for financial reasons, they had no choice but to make substantial closures.[18] I am convinced that they were broadly right in that. The NHS Management Board, of which I was a member, supported me in the view that we should make a fairly substantial bid – higher than usual. The bids that had been accepted in previous years had been, essentially, 1per cent for demography minus 0.5 per cent for efficiency and a few little fiddles, if you could find something that they [the Treasury] might be convinced about. They were pretty limited. The 1per cent for demography was probably sound. The means by which the 0.5 per cent efficiencies could be found were never clear-cut.

We put in a higher bid. John Moore, of course, became our Secretary of State, and I have to say that I have met more impressive Secretaries of State in my time [Laughter]. [19] He formed the view that, because he had been Nigel Lawson's junior minister, he had a special route to Nigel Lawson, and it was clear to us that he thought he could just bypass the whole system. He could not and it created a very bad atmosphere.[20] John Major was furious, and it was patently obvious, when we got to the meeting, that Sir John Major was furious with him, however much things have been more politely put in the biographies – and I have read all the relevant biographies, including yours, Ken.[21] The officials were even more furious. They somehow seemed to think that we had put him up to it whereas we had not even known he was trying to do it until he had failed to get to first base.

The officials we dealt with were extremely negative throughout and this carried on into the actual negotiations. We had something like three bilaterals. The third of these – and you will see in a moment why I remember the date – was on 15 October 1987. It went on until about 9.00 in the evening and then there was a short break, and we assumed that we would resume, instead of which the future head of the civil service, Sir Robin Butler, came in and joined our minister [Secretary of State] and the small team with him, and said, 'We think we cannot go any further; however, there is to be a change in the forecast of the GDP deflator, which will be announced tomorrow, and that will be worth an extra £50 million to you compared with the other government departments that have already settled.[22] That offer is open tonight.'

We adjourned. I think we had no doubt whatever that we were going to have to agree. I was waiting for a government car, because I was allowed one to take me home, given that it was about 9.30 at night, with my fellow Under-Secretary. We were waiting there when the Treasury Assistant Secretary

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[18] John James later added that 'the 1987 Election required that no controversial actions be taken in the run up, so HAs were told that they should not propose closures in the run up. Once the Election was over, many made announcements later than they wishes, requiring deeper cuts.'

[19] John Moore was Secretary of State for Social Services (1987-1988) at the time when it combined health and social services portfolios.

[20] Nigel Lawson was Chancellor of the Exchequer (1983-1989).

[21] John Major was Prime Minister and Leader of the Conservative Party (1990-1997).

[22] Robin Butler was Principal Private Secretary to the Prime Minister (1982-1985) and Second Permanent Secretary to the Treasury (1985-1987).

Image 4: John James

came up to me and said, in front of both of us, 'I have been told to tell you that, if you do not stop advising your Secretary of State to say no, it will do your civil service career harm.' I was not told who it came from. The fact that Robin Butler was about to become head of the civil service was probably meant to have an influence on who I thought it might have come from – I do not believe it did come from him.

I went home. The storm broke – literally – that night.[23] We could not get into work. John Moore and Chris France could.[24] I worked from my kitchen table, Mike Lillywhite worked from his, except when he was cutting up the tree that had fallen over his fence, and we did the deal – or so we thought.[25] When we got further confirmatory letters a day or two later, it became apparent that the figures we thought we had got were not, in fact, the figures the Treasury had given us. A very ambiguous letter had contained two possible interpretations. I went to see Chris France and explained the issue. He said, 'Yes, I think you are right. We will ring Robin Butler and you listen in.' Robin Butler had all the issues absolutely at his fingertips and he said, 'No, it is absolutely the way we said it. John James is wrong.'

I thought then that I was probably going to have done only one public expenditure round before being moved on. I did not tell Chris about the threat but I did tell my Principal Establishment and Finance Officer, John Maine. He then went and interviewed all the senior people in the Treasury – all of the significant ones – with the basic question, 'Are you saying you do not have confidence in him?' and they said, 'We do have confidence.' The following year, I negotiated with a completely different team – on their side, that is.

Nicholas Timmins

The outcome, however, of this was not enough money.

John James

The outcome of this was absolutely disastrous. We put the best face on it that we could. Immediately, the shortcomings became absolutely clear, and I think the Treasury were probably as surprised by the reaction to this as we were. There was no way we could hold it. We did a temporary attempt whilst other things were going on. The [NHS] Management Board persuaded Tony Newton to apply for £100 million in the current year: £60 million of that for damages caused by the storm, and £40 million to write off a system whereby, if any health authority underspent in a year, it was entitled to add the money to its allocation the following year, but there was no means by which we could get our hands on it, so we had another £40 million problem there.[26] That approach succeeded but, by the

[23] A reference to the severe storm of the night of 15-16 October 1987 that damaged large areas of Southern England.

[24] Christopher France (1934-2014) was Permanent Secretary in the DHSS (1987-1992).

[25] Mike Lillywhite entered the DHSS in the 1970s, was Principal Establishment Officer and then an Under-Secretary in the DHSS and then Department of Health (until mid-2000s).

[26] Tony Newton (1937-2012) was Minister of State for Health in the DHSS (1986-1988) and Chairman of the NHS Management Board (1986-1988)

time of the Prime Minister's announcement on *Panorama*, it was absolutely clear that the situation was wholly unresolved for everybody.

Nicholas Timmins

Just to move a little back from that, the '86 settlement was also very tight, and the word went out just ahead of the '87 election. Managers were just told to keep the lid on, and they did that mainly by ceasing to pay their suppliers, to the point where some of them owed about a quarter of the non-pay budget to their suppliers. In July, Ian Mills, who was the Finance Director for the Management Board, had the pleasure of telling Tony Newton that, technically speaking, the NHS was bankrupt. If it had been a private-sector operation, it would not have been a going concern.[27] That was happening ahead of what you have just described, and health authorities were starting to close beds. As soon as that settlement became clear, they shut them, literally by the thousands.

Professor Nick Bosanquet

I will give a picture from outside the civil service. I think, for Sally's history, we should remember the row over the CPRS [Central Policy Review Staff] report on the welfare state in 1983, which was very powerful in blocking off any deep investigation into alternatives to the NHS.[28] [29] However, soon after that came the Griffiths report on management, which revitalised the IHSM [Institute of Health Services Management] and other bodies, which became much more involved in thinking that they could start influencing national policy.[30] [31] Before, they had been perhaps a little bit of a dining-out group – or dining-in group – before Ken Jarrold, John Marks and Barbara Young, who were the main drivers behind it.[32] They commissioned the York report on health funding, which I think was the first time that the aggregate variable of health funding had come back into play since the Guillebaud report.[33] [34] It had never really been discussed in the previous twenty years, except as part of the public spending round.

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[27] Ian Mills is an accountant by training. He was Director of Financial Management (1985-1988) and Director of Resource Management (1988-1989) on the NHS Management Board.

[28] The Central Policy Review Staff was a think-tank set up within the Cabinet Office in 1971 and was disbanded in 1983.

[29] A CPRS report of September 1982 discussing, among other welfare reforms, the replacement of the NHS with a privatised healthcare system was leaked to the press.

[30] In 1983, Margaret Thatcher set up the Griffiths NHS Inquiry, headed by Sainsbury's Director, Roy Griffiths, which made recommendations, in what became known as the Griffiths report, for the introduction of general management in the NHS. This included the need to include clinicians in the management of healthcare organisations, the attempt to separate the politics from the management of the NHS with the creation of the NHS Management Executive, and evaluating the performance of the service.

[31] The Institute of Health Services Management (now Institute of Healthcare Management) was created in 1984, having changed its name from the Institute of Health Service Administrators.

[32] Barbara Young was District General Manager of Paddington and North Kensington Health Authority (1985-1988).

[33] Bosanquet, N. (1985), *Public Expenditure on the NHS: Recent Trends and the Outlook*, London: Institute of Health Services Management.

[34] The Guillebaud Committee into the Cost of the National Health Service was formed in 1953, chaired by Claude Guillebaud, a Professor of Economics at Cambridge. The Committee reported in 1956, concluding that the NHS was financially sustainable but would require extra funding in the future.

That report clearly set out that there should be at least 2 per cent a year real growth – surprise, surprise – strongly backed by Ken Jarrold and others. That got a lot of attention at the time and I was known as Mr 2 per cent, and the then minister – Barney Hayhoe – blamed me for ruining his career. That, I think, got into Whitehall and certainly into the Prime Minister's and her assistant's view that there was something very nasty about to happen, which was that the NHS was a kind of Frankenstein['s] monster that was going to lead to a hell of a lot more funding over the next ten years, at a time when they did not want more funding; they wanted, in fact, to reduce public spending, so this was totally contradictory. I think that is why they set up the inquiry, to find a way of containing funding in the future.

Kenneth Clarke

I agree with most of that. The background to all this was that the NHS was in crisis because it was completely unchanging and entirely dominated by the public spending round, with people outside the health service wishing to constrain the amount of health, and people inside the Department wanting to get more funding because, the way they were going, it kept causing all kinds of difficulties and nothing was changing. That was the root of the problem, which seemed to me perfectly clear when I was Minister of State. That is why I did not mind being appointed and brought back to the health service on the agenda of reform, until I discovered the reforms they had in mind, which struck me as idiotic [laughter].

You mentioned Griffiths. This was all part of this. You had to get more money because, otherwise, you would have closures. Well, the health service bloody needed closures. We had some appalling dumps that should have been closed – all those geriatric hospitals, which were workhouses renamed. The Griffiths report showed we had no idea what we were spending the money on. There was no management information. The system worked, to use a phrase I was fond of using, very much like the Indian state railways – another delightful organisation. Everybody conscientiously did, each year, what they had done the year before, without anybody questioning whether this was quite the sensible way of going about it.

Remember that marvellous thing, the limited list, when I tried to introduce some banal little changes to the liberty of a GP [General Practitioner] to prescribe things.[35] This was regarded by John Marks and others as revolutionary. Doctors were not meant to bother about what anything cost, and neither were ministers. It screamed out for reform. It would not have lasted staggering on in this way, and Enthoven provided the solution because, unfortunately for Margaret, I had read Enthoven's stuff in *The Economist*.[36] I turned up with bees in my bonnet that did not resemble hers, but the great bulk of the system, which is true to this day, was just resisting change. It did not want anybody to change anything; it was just that the Treasury had to find some more money to keep everybody happy.

Speaking as the iron of the Treasury later entered my soul as Chancellor of the Exchequer, it is simply an impossible way of proceeding. You cannot just sit there with people who say, 'We have to do things exactly as we have always done them. Sorry it is not working very well. Meanwhile, we work out that we need this amount next year to keep us solvent doing it.' The case for reform screamed out. The problem was finding out a) what reforms we wanted to try and b) how to get this huge oil tanker, resistant to change in any direction, to change direction in a practical way which would work,

[35] In 1984, Kenneth Clarke, who was then Minister for Health, introduced a reform known as the 'limited list' which aimed to curtail the rising cost of prescribed medicine by outlining a list of 1800 products which would be available on the NHS, those left out believed to be clinically inefficient/effective

[36] Enthoven, A. (1985) 'National Health Service: some reforms that might be politically feasible', *The Economist*, 22 June 1985, pp. 61-64.

which had failed with the previous attempt by Keith Joseph, catastrophically, because he took this stupid McKinsey's report and brought in consensus management.[37] [38] [39]

Nicholas Timmins

We will come back to all that later. I want to jump to the point where Maggie appears on television and announces this, but is there anything this side of the table that you would like to say about the run-up to that?

Professor Marshall Marinker

Nick, you will remember Lord Vaizey brought together a think-tank in Cumberland Lodge with the title 'A New NHS Act for…' – I cannot remember what year it was meant to be.[40] [41]

Professor Nick Bosanquet

1990, I think.

Professor Marshall Marinker

Something like that. The members included Nick [Bosanquet], Alan Maynard, the CMO [Chief Medical Officer, Donald Acheson], the Deputy CMO, and the Treasurer to the Department, and I was the only representative of general practice. In fact, I was no longer a GP at the time; I was running a foundation in – my God, it is John Marks [John Marks enters the room]. This is really a ghost from the past [laughter].

Dr John Marks

The reason I am late is quite simple: as I was leaving home, I was held up by the police because someone had got into my bank account and stripped it, and they insisted that I remain there, there and then, and be interviewed. They had arrested somebody so I am now half an hour late. I am very sorry.

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[37] Keith Joseph (1918-1994) was Secretary of State for Social Services (1970-1974).

[38] This is a reference to the 'Grey Book' or the *Management Arrangements for the Reorganised National Health Service* report which was published in 1972, as a product of the work of a DHSS study group including McKinsey management consultants. See the transcript of the witness seminar on the 1974 NHS Reorganisation held on 9 November 2016:https://www.liverpool.ac.uk/media/livacuk/instituteofpsychology/researchgroups/GoH,The,1974,NHS,Reorganisation.pdf

[39] The principle of consensus management was one of the innovations offered by the Grey Book (cf. footnote 38) which led to the creation of management teams in each health authority. These included a medical professional, a nurse, an administrator and a finance officer and required decisions to be made collaboratively and on an equal footing. In the post-1974 reorganised NHS, this consensus management led to sclerosis in some health authorities where decisions could not be agreed.

[40] John Vaizey (1929-1984) was a political adviser and Professor of Economics at Brunel University (1966-1982).

[41] Cumberland Lodge is an educational foundation founded in 1947. In September 1983 and June 1984, the Lodge, whose principal was then John Vaizey (1982-1984) (cf. footnote 40), hosted two meetings at which Margaret Thatcher discussed the future of the welfare state and of the NHS with senior academics and policy-makers. Marinker, M. (1984), *A New NHS Act for 1996?*, London: Office of Health Economics.

Professor Marshall Marinker

John, I promise you it was not me [laughter]. When I tell my story, I think that you will agree that I would have been justified. The think-tank began with lots of presentations by Alan, Nick and others of NHS statistics at the time. I have to tell you that I was a total stranger to that world. My professional interests had nothing to do with organising the health service or the politics of it; I was interested in reforming medical education, what doctors were taught and how they were being taught it. For some reason, I found myself in this rather august group of experts. Vaizey then said, 'We have been asked by Margaret Thatcher to think new thoughts', and there was a long silence. I literally began to think aloud. I am sorry to tell Ken Clarke this, but I believe that I invented fundholding at that moment [laughter].[42] Not only did I invent it but we published.[43]

Kenneth Clarke

Really? Very good.

Professor Marshall Marinker

I claim no great originality, I had already read Enthoven, and all of us were in that world of new ideas. I began just thinking aloud and gradually began to develop the idea that money would follow the patient, that the general practitioner – who was the clinical manager of the patient's problems, or should be – we haven't got there yet but it was a good idea back then…

Nicholas Timmins

That is part of the original idea. Any idea like that ends up having many fathers, so Alan Maynard would claim some credit and Nick [Bosanquet] would claim some credit.[44]

Professor Marshall Marinker

Alan Maynard certainly was a co-parent, because he immediately began to add items to such a contract, beginning with items of elective surgery… This was really the end of my innocence as a general practitioner. It almost ended up with John [Marks] – an old friend from way back – trying to get me sacked from my job for having become politicised.

Nicholas Timmins

We will leave that history aside for the moment. Graham, anything about the run-up to Thatcher appearing?

Sir Graham Hart

If I could just add very quickly to what has been said. It was a very difficult time, that second half of '87. NHS management, in its form that we then knew it – the regional chairs in particular and the regional managers and so on – had been definitely tipped the wink that an election was coming up in

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[42] This is a reference to the claim that Kenneth Clarke 'came up with GP fundholding' on a holiday in Galicia, Spain This is contested by a number of stakeholders in the health policy arena. See Timmins, N. (2017), *The Five Giants. A Biography of the Welfare State*, 3rd Ed., London: William Collins, p. 462.

[43] Maynard, A., Marinker, M. and Pereira Gray, D. (1986), 'The doctor, the patient and their contract', *British Medical Journal*, 292: 1483-1440.

[44] Alan Maynard (1944-2018) was lecturing in economics at the University of York from 1971. He was Director of the Graduate Programme in Health Economics (1977-1983); Professor of Economics and Founding Director of the Centre for Health Economics (1983-1995); Professor of Health Economics (1997-2014), then Emeritus.

the middle of '87: 'Try not to rock the boat, chaps' [laughter]. I think a lot of things that could have been done – and, in other times, would have been done – were not done, and the problem built up. Then, as John [James] has said, there were hopes of a good settlement from the public expenditure round which culminated on October, 16th-17th, the Great Storm day – I remember it well. I was marooned in Colin Walker's house in Suffolk, with my car under a tree, so I remember it very well.[45]

What we are slightly underplaying, I think, is that, somehow, in this mysterious way that these things happen, a genuine sense of crisis in the NHS was generated that autumn. Nobody has mentioned the press. There was a tremendous amount of media coverage. There was all the business with babies in Birmingham Children's Hospital.

Nicholas Timmins

David Barber – the hole-in-the-heart baby who died.[46]

Sir Graham Hart

Yes. This is all very powerful stuff.

Kenneth Clarke

It happened about every two or three years.

Sir Graham Hart

It is quite true, Ken: it happened from time to time. However, some ministers are more robust in dealing with it than others, if I may say so. I think that the official response, if I can put it that way – the political response to all this – was not very strong.

Image 5: Graham Hart

Nicholas Timmins

There was not any.

Sir Graham Hart

There was very little fightback to say that everything is going to be alright, and I do not think that the NHS Management Board or its chairman, the late lamented Tony [Newton], did think it was going to be alright. We thought it was pretty hairy and something needed to be done. That is the background to Tony going off and doing a small deal on the side with John Major and coming back with £100 million. Number 10 and the Prime Minister were pretty upset about all this. I think they thought it was very bad news.

The only other thing I wanted to say, which is not a personal testimony, is that, if you look at Nigel Lawson's book, he claims that Margaret's announcement on *Panorama* followed very shortly –

[45] Colin Walker (1934-1999) was Chairman of the East Anglian Regional Health Authority (1987-1994).

[46] See Timmins, N., *The Five Giants. A Biography of the Welfare State*, 3rd Ed., London: William Collins, p. 451-470.

maybe even the next day – after a dinner that he had with her, at which all these issues were discussed.[47] Whether there was any plan in her mind about where it was all going, I do not know.

Nicholas Timmins

She goes on *Panorama* in January '88 and announces that an NHS review is underway. This is where you come in, Strachan [Heppell], but I can remember Richard Wilson, the future Cabinet Secretary who was number three in the Cabinet Office at the time, telling me the story.[48] He was sitting there watching *Panorama*, like everybody else, and she said that there is an NHS review underway. He thought, 'Oh, right. So, that is what I am doing for the next three days: setting one up' [laughter].

Bob Nicholls

John Moore was mentioned as not very strong, and that has been echoed in part in your book, Ken. But John Moore had been chosen by Maggie because he had done privatisation. He was pro, with a little group which faded, an insurance system. If he had not got ill and been replaced by Ken, what then…?

Kenneth Clarke

They were going to go ahead, as you say, with their alternative, which was, essentially, tax relief for insurance. They were going to an insurance-based system. We are all agreed. Where they were all at loggerheads, with the wisdom of hindsight, I was not involved in '87, so I am slightly detached. Where you got to in 1987 was the Department was doing its best to get more money because, as they quite rightly say, going on as it was, the National Health Service was crashing and there was nothing much changing. The only thing that the Department could do was to desperately try to get more money out of the Treasury. The Treasury was resisting.

Meanwhile, Margaret had decided that defending the NHS against these permanent crises of babies not being treated and all this kind of thing was hopeless with her statistics, and something had got to change. She had got convinced that the NHS was fundamentally flawed and you had to go over to something like the American system. There had to be some private finance story, and she had a little group, I gather, which I was not a member of, and what was described a few moments ago was getting a think-tank together in Cumberland Place [Lodge] and us asking, 'Have you any ideas about how we should change it?'

The trouble was that they had come to no real conclusion, except John Moore told me that he and Margaret had reached this agreement about how you had to have tax relief for private insurance and the government would pay a reduced rate of insurance for everybody who could not afford it, so you provided the basic system, and that Nigel Lawson was screwing it up because he was refusing to give the tax relief. That is where it was, so they had announced that this reform was underway and Richard Wilson had had to get some group underway to look at this reform. They had not come to any real conclusions that were agreed upon, but they were just committed to change. Quite a lot of us, apparently, read Enthoven, who was the key to the whole damn thing, which they had rejected, as someone said a moment ago. They had looked at it and this marvellous think-tank group had turned it down, so, it did take a little difficulty to persuade Margaret to go back to it, with the purchaser-provider and GP fundholding.

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[47] This is a reference to Lawson, N. (1992), *The View from Number 11: Memoirs of a Tory Rebel*, London: Bantam Press.

[48] Richard Wilson was Deputy Secretary in the Cabinet Office (1987-1990).

Dr Graham Winyard

I moved into the Department for the first time in the autumn of '87 from Lewisham & North Southwark [District Health Authority], which was Guy's and Lewisham. I was going to say that I think one of the elements in the mix, it felt to me, was hospitals such as Guy's were lobbying passionately about the fact that the system, as it then was, punished centres of excellence that could attract lots of patients – that the money did not flow with the patients and this was seen by them as an outrage. They seemed to be quite well-connected in to the Prime Minister in ways I never fully understood, but you felt that Ian McColl could bend ears.[49] From day one, it felt that the Department was under siege, with each day bringing new stories of service shortcomings which regional liaison and its medical group had to devise responses to.

Image 6: Graham Winyard

Kenneth Clarke

That was their case. Everywhere lobbied. The whole world was lobbying. Because the whole point was money, wherever you went in the country, they lobbied. Guy's would argue that, as a centre of excellence attracting lots of patients, this was their case. If you went to Wakefield, too much money was going to London, all the money went to these crazy, unnecessary, prestige hospitals which were all next door to each other, and poor Wakefield was losing out on money. The whole debate was about money, and that is because nobody was addressing what the Griffiths report identified. The fundamental problem was that nobody was running anything and nobody was analysing why they were in financial crisis. Nobody knew why we were in financial crisis. You ran whatever bit of the health service you were responsible for on your annual allocation. Sometimes, you found you ran out by about January; sometimes, you had something left over – you ran around asking anybody if they wanted to buy any new kit that they might need in the next few years and so on, until you used it up, but usually you ran out. What did you do when you ran out? You telephoned *The Guardian* [laughter] and described what the disasters were. This was 1987.

Nicholas Timmins

We have a couple of managers in the front row here. Is that how it felt?

Ken Jarrold

First of all, it has been a privilege for me to hear that discussion from people who were at the centre of this, so thank you, Sally, for that. It has been really powerful for me.

Second, I absolutely understand what Ken was saying about the health service constantly moaning, but there was something different about the York report that Nick referred to, which I commissioned as President of the Institute of Health Services Management. I was delighted when John Marks, the

[49] Ian McColl was Professor of Surgery, University of London at Guy's, King's and St Thomas' School of Medicine of King's College London (1971-1998) and Director of Surgery (1985-1998) and Consultant Surgeon (1971-1998) at Guy's Hospital. He subsequently became a peer and Jon Major's Parliamentary Private Secretary in the House of Lords.

British Medical Association [BMA] and the Royal College of Nursing [RCN] joined us in that report, because it was a serious attempt to set out an economic case for the NHS, and I do not think it had been done in that way before.[50] [51] It was not all moaning – there was a bit of an attempt to establish a respectable case. John and I, with the RCN, went to see Barney Hayhoe and he dismissed us utterly, and we could see we were not being taken in any way seriously.[52] He was Minister of Health.

The other point I wanted to refer to was the enormous importance of the Griffiths report, because everything else that we are going to discuss this afternoon would have been, in my view, impossible without this. I was deeply suspicious when Griffiths was appointed: this man from Sainsbury's coming to meddle with my precious NHS.[53] Then I discovered, however, that he was a miner's son from North Staffordshire whose commitment to the NHS was every bit as strong as mine, and what he did made everything that has followed possible and we owe him a huge debt.

Bob Nicholls

I agree with Ken Jarrold about Griffiths, and certainly Ken has made that point in his book. What it exposed was the lack of information and the lack of anybody having any idea about what things cost or what the outcomes of what we were doing were. However, you accused us managers. What Ken described, I'm guilty as charged. We were desperately poor in the South West. I had worked all my time at St Thomas' in London but they had all the bloody registrars, the fellows and the researchers. I wanted some down in Bristol and Cornwall. So, yes, Griffiths enabled and challenged the lack of information and the need to do something. I would agree with Ken that, without it, I do not know how he and others would have taken things forward.

Kenneth Clarke

Roy Griffiths was crucial in persuading Margaret. I was really indignant that, as a new Minister of State, she was getting this bloke in from Sainsbury's [laughter]. What had I been appointed for if some mate of hers from Sainsbury's was now meant to be coming in and telling me what to do? It took a long time for me to reconcile to him. Margaret had a lot of time for Roy Griffiths. Roy Griffiths started from a position which I did not and you did not. She was ready to listen to Roy Griffiths. Roy Griffiths could persuade her. He was a captain of industry. She liked him. One thing that she cannot be accused of is neglecting detail – she read everything. His analysis paved the way for getting her to look at the things that Bob Nicholls and I have just been persuading you about: 'Why do we not have any information? Who the devil is in charge here? How can you change things to accommodate the budget that you can get out of the system?'

[50] The British Medical Association, created in 1832, is the trade union and professional body representing doctors in the UK.

[51] The Royal Collage of Nursing, founded in 1916, is the trade union and professional body representing nurses in the UK.

[52] Barney Hayhoe (1925-2013) was a Minister of State for Health (1985-1986), DHSS and later Chairman of Guy's and St Thomas' NHS Trust (1993-1995).

[53] Roy Griffiths (1926 - 1994) was Managing Director of Sainsbury's (1979-1988) and Chairman of the Management Inquiry into the NHS (1983) which oversaw the introduction of general management. Griffiths, R. (1983), *NHS Management Inquiry*, London: DHSS.

Image 7: David Walker

David Walker

I was a leader-writer on *The Times*. Do not forget the strength of the ideological content. As a leader-writer in *The Times* – a Murdoch paper close not only to the Prime Minister but to those American influences around her – Enthoven was certainly, to us, a market guru. The importation of market principles into the NHS was key, and his report, symbolically at least, was a huge factor in that.

Nicholas Timmins

When it was set up, do you want to say anything about the early bit of it? We have started to cover this but one of the most striking things about the Thatcher review was that it started out all about money and refinancing the NHS and ended up being about changing the way it ran, with the biggest vote of confidence in the funding system from Margaret Thatcher in the foreword you got her to write that I had ever seen. It started out about one thing and ended up as something other.

Strachan Heppell

The *Panorama* programme – the 'Big Bang', if you like – started things off. We had not prepared for a reform, as is common knowledge, so we were starting from scratch. It came to me because I was in charge of health and social service policy. I had also, as it happened, done the social security reforms earlier in the decade. We were in addition in the process of doing the community care reforms. What we did, then, in the best Whitehall traditions, was to set up a small group to get on with it.

Seeing Graham Winyard there, I remember we had an initial meeting around my table, and Graham was emphasising the importance of pushing responsibility down the line. That became one of the later themes, of course. The review started off about money but we spent relatively little time on the financing of the health service. Much of the debate on financing took place outside the Department, as we have heard. So far as we were concerned in the Department, the papers we produced argued in favour of funding from general taxation and against any idea of having direct health taxation or adapting the National Insurance system. We did not offer any support for any contracting out. The reason why we had contracting out from social security was because you had a lot of large private pension funds in existence, and that had to be acknowledged. That did not exist in health and it was plain that the cost of setting up any health-based insurance system would simply put up the administrative cost of healthcare. The last thing we wanted was to finish up paying a significant proportion of healthcare on administration, as in the United States, so we did not support it. The only small part of this that eventually was agreed were the special arrangements for tax relief for private health care subscriptions paid by the over-60s.[54]

[54] Strachan Heppell later added: 'The origin of the reforms was straightforward. The NHS was under very strong pressure and was short of money. Pressure came from the growing demand for health care and from the higher expectations of patients, the public and the media. The Government recognised this; and that as a result the NHS needed more money. But before putting in more money, Ministers wanted to be sure that it would be well spent.

Nicholas Timmins

Enthoven keeps cropping up. There was a hope he would be here but he is not, although he has answered a bunch of questions that he got asked.[55] I will not go through it all but what I find most interesting about it is he was invited over and he wrote his report on the management of the health service. Apart from the academics he talked to, he talked to no one in government. He says he had no contact with ministers and no contact with officials.

Bob Nicholls

He had contact with the regions.

Nicholas Timmins

He talked to the health service but he did not talk to the centre.

Kenneth Clarke

I thought I might meet him for the first time today [laughter].

Nicholas Timmins

David [Walker] may have a different memory but my memory is that, when it was published, Gordon McLachlan clearly made sure that people in government read it, but he did not give it a big push. I was on *The Independent* and I do not think I was sent a copy.[56] I do not remember that at all. I do remember reading the piece in *The Economist*, which I think was the one bit of press coverage that it got when it came out. *The Economist* did the first piece and very presciently said that this could be quite important, which I thought was a brilliant piece of journalism, because it turned out so to be. It had, however, clearly penetrated, because you talked about the Cumberland Lodge stuff. David Willetts had been health advisor in Number 10 just ahead of this and gone off to the Centre for Policy Studies.[57] One of the things that Thatcher said to him is, 'Do some thinking for us about healthcare.' I remember reading *The Economist* piece. Journalists were trying to find out what was going on in this bloody review. I remember David saying to me, 'Read Enthoven, because that is probably where it might end up.'

David Walker

He was clearly being promoted by people. John O'Sullivan subsequently went off to the Heritage Foundation and Enthoven was being promoted as the guru who would solve the problem of marketising the NHS.[58]

That led to the review of the NHS and to the proposals in the White Paper "Working for Patients" published in January 1989, a year after the initial announcement.'

[55] See Appendix 1.

[56] Nick Timmins was Health and Social Services Correspondent at *The Independent* (1986-1990).

[57] David Willetts was a member of the Prime Minister's Downing Street Policy Unit (1984-1986) and Director of Studies at the Centre for Policy Studies (1987-1992).

[58] John O'Sullivan was Special Adviser to Margaret Thatcher during the 1980s, and also held editorial roles at *The Times* and *The Daily Telegraph*. He was Director of Studies at the Heritage Foundation, a Washington-based conservative and pro-market think-tank (1979-1983).

Kenneth Clarke

We all believed in free-market economics. It was quite a range of people, most of them predictable. When John O'Sullivan read it, he would come to the same conclusion. We read it and what I do not understand is why Thatcher – she apparently had some little group looking at it and was desperately trying to get them to find some things to change – is why it was rejected, because people like David Willetts, John O'Sullivan and, by chance, me, who shortly afterwards was asked to go in as Secretary of State, had really thought, 'This is more like it.' It was rather puzzling, when she was desperately searching for something to persuade her that the health service was reformable and could keep going, why it was rejected.

Sir Graham Hart

Is that something that you would have written into your manifesto in 1987?

Kenneth Clarke

I never read the party manifesto [laughter].

Sir Graham Hart

It would not have got written in – that is what I am saying. It was not the right time to.

Kenneth Clarke

It probably was. You could not announce it as policy before the election. We did not have a policy before the election in the sense that we had not cut the service and you would have had to have more money.

Jonathan Shapiro

Nick, can you clarify who actually invited Enthoven in?

Nick Timmins

The Nuffield [Trust].

John James

The reason why it was rejected – i.e. they could not do it because there was not level funding for health authorities – links in with the way in which the problem was resolved. During the review, we worked out how to make sure that we knew how much was being spent on the populations covered by each of the health authorities in the country. That was crucial. It was, in effect, done by reversing cross-boundary flows. You would find that a particular health authority – and I went to Harrow in 1990 – had a budget of only £40 million plus a bit extra for the clinical research centre, but it was getting £60 million worth of healthcare for its residents. The other £20 million was being exported, firstly to Mount Vernon, which provided all the cancer care, and secondly to the inner London hospitals. Once we cracked that, we could ensure that the changes would come in on a level playing field, in the sense that you could buy what you had bought in the previous year. You did not know you had bought it – quite an important gap – but you could start there and then you could move forward [to] how you ensure level playing fields in the future. That was a crucial breakthrough.

Professor Nick Bosanquet

Just to try to help Sally with her very difficult task, the new thing that has come out of this discussion is that there was a push for reform from below. There had been nothing like that in the health service

in the previous twenty years. It was a very static and very complacent system, so this was a new feature, together with the media pressure. Let us hope that Jennifer is doing well now, but this was the first time that anybody had mentioned an individual patient in an election campaign – that had been completely taboo before.[59] That alerted the politicians to a new level of intensive and poignant campaigning around the health service.

Nicholas Timmins

Jennifer's ear was in 1992 – I was there.

Professor Nick Bosanquet

The Birmingham babies were the first to be mentioned individually, which threatened a new kind of political campaigning.

Nicholas Timmins

Just to emphasise the point about pressure from below, Ken Grant, who was Chief Executive of Bart's [St Bartholomew's Hospital, London], which had a new artificial sphincter [implant] that cost a fortune, started charging other health authorities for it, if they put it in, saying that this was the beginning of internal markets. That was before the review came out. John Moore gets fired and you come along. My impression is that there was the row about the money, where you finally settled for over-60s only, Ken, but it moved from being about finance to organisational structure.

Kenneth Clarke

That was Nigel [Lawson]'s. The tax relief for older patients was Nigel's – a minor concession that he knew was not worth tuppence to stop Margaret going on at him about tax relief. That was just to get rid of him. Then what happened was she discovered that, firstly, Nigel was still resisting, so he was fobbed off, and the discussion moved on to me seeking to persuade her to move to purchaser/provider. What is encouraging about all this is that we were not all completely mad, because what has been revealed is the astonishing number of people who keep saying that Enthoven's thing, which was not terribly complicated – he was not a health economist but a defence economist – struck a chord in several very different people looking at the health service.

The problem then was persuading Margaret, who had already rejected this, that this was worth doing. Poor old Richard Wilson did brilliantly, producing minutes of meetings between me and Margaret Thatcher which were just rows. The two of us were both quite combative, so they really got into shouting matches at times, at the end of which Richard would solemnly produce minutes of the conclusions we had reached and how the conversation had moved on. I said, 'I will ring back my private office and mark this particular meeting on the Richter scale' [laughter], because I knew what I would be like by the time I got back. This went on for well over ten meetings, with just the three of us in the Cabinet room, arguing about Enthoven.

John James

That really is what you say in your 'Blue Note' book but I understood from them that Nigel Lawson and John Major were there as well.[60]

[59] The 1992 General Election campaign was dominated by the NHS and the Labour Party exploited the case of 'Jennifer's ear', the case of a girl who had to wait longer to have surgery on her ear due to NHS underfunding.

[60] This is a reference to Clarke, K. (2017), *Kind of Blue: A Political Memoir*, London: Pan Macmillan.

Kenneth Clarke

No.[61]

John James

That is what they told us.

Kenneth Clarke

There was nobody from Treasury there.

John James

We got these reports back and I was allowed in – I was slightly bogus, I think. It was really just Strachan and his team who should have been there, but I was there as well. We got these feedbacks and there was one who came back and said, 'We had a really exciting debate today.' Then the Richter scale report came through and, by the following morning, you were distinctly less ebullient [laughter].

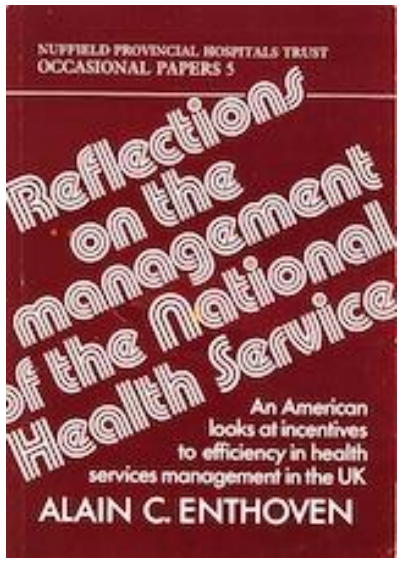

Image 8: Front cover of Enthoven, A. (1985), *Reflections on the Management of the National Health Service*, London: NPHT.

Kenneth Clarke

Richard's conclusions had not gone the right way.

John James

The following meeting was much easier, and then the following meeting, she was difficult again, so we reserved the more difficult issues for the meetings when we knew she was going to be more reasonable and you were part of that.

Kenneth Clarke

I do not know why she was so difficult. With hindsight, if anybody was king of market solutions to most things, it was Margaret Thatcher. I never could quite work out why she was positively hostile to it. For Nigel Lawson, the main interest was to stop spending more money on the health service and to stop being pressed to give tax relief that he did not want to give, so he just washed his hands of it once he was let off the hook. He vanished from the discussions and let us get on with it. Then she suddenly – as she often did on other things where, contrary to belief, she changed her mind – turned up one day all sweetness and light. She had decided, 'Alright, we had better get on with it' and all that kind of thing. It all fizzled out and Richard was able to do a rather more sensible, organised report, in joined-up writing, of this amazing agreement we had now all reached and we were going to work out the idea of purchaser-provider.

Professor Sally Sheard

Alain Enthoven sent me through a statement. I put some questions to him, which he has very kindly answered, and he concludes: 'Let me conclude by saying I did not see myself as putting forward a well-thought-out plan. I thought I was sending a thank you letter for a very pleasant visit to the UK

[61] Here, John James later added: 'John Major's autobiography lists the Ministerial attendees, Prime Minister, Chancellor, Chief Secretary, Secretary of State for Health and Minister for Health. This is also in accordance with my personal recollections of the meetings to which we were summoned the moment Ken returned from these get-togethers.'

with a few tentative suggestions.' I think Enthoven's view of what he did is very different.[62] That is a comment.

I also have a question that comes back to Ken Grant, Bart's, the new sphincter and charging. Ken Jarrold, you had been operating some sort of purchaser-provider split in Gloucester in 1984-85?

Bob Nicholls

I was his regional administrator. I did not know about that!

Ken Jarrold

I really do not remember [laughter]. All I would say – and I would love to come to it later, if I may – is that one of the reasons I was delighted by Ken's victory, which I regarded as a fantastic victory over Mrs T – thank God Ken was there; if it had been virtually anybody else, God knows where we ended up. One of the things I was keenest on from Ken's reforms was the creation of the NHS Trusts.[63] What we had done in Gloucester was to try to make sure that the health authority was a planner and that our units of management that had been created in '82 were given maximum devolution.

Professor Sally Sheard

That is what I wanted to get on record.

Image 9: Sally Sheard delivering the statement of Alain Enthoven.

[62] See Appendix 1.

[63] As part of the 1991 NHS reforms, hospitals could apply for the new status of 'trusts' which afforded more independence.

Nicholas Timmins

That is exactly it. If you read Enthoven, what he is talking about is a very loose purchaser-provider split, where patients move around between health authorities. It is not the blueprint for what happened because he does not have NHS Trusts in it properly. It certainly does not have fundholders in it. It is less of a market than what emerged. It is the germ of the idea and certainly not the blueprint.

Kenneth Clarke

Within the Department, quite a lot of Department officials – and I was keen on this as well – liked responsibility downwards, accountability upwards. You could just lead them all around the market and then blame the government and go to *The Guardian* again when it went wrong because they had made a pig's ear of something, but the idea was that we stop trying to run everything from the centre and we put responsibility in the hands of purchasers, fundholders. The job of the Regional Health Authorities, and our job was to hold them accountable, including when things went wrong. That rapidly caught on. I had forgotten that Enthoven had even gone that far, so it was the germ of the idea of purchaser-providers.

Professor Nick Bosanquet

One major advantage of Enthoven is that it is a well-written and very vague document that could be attractive to various levels of reformers. There were the pro-NHS reformers and also the anti-NHS reformers, and they were, to some extent, brought together because they were, at another stage of the Enthoven plan, even more vaguely sketched out where they were going to move to accountable care organisations.

Image 10: Rudolf Klein and Nick Black

Professor Rudolf Klein

I want to clear up a small puzzle. When I interviewed Ken Clarke about the reforms, he was inclined at that point to downplay Enthoven, and he made a very interesting point that the idea that drove things was the example of schools. The government had introduced reforms earlier that rewarded schools for attracting custom and so on. So which Clarke is this?

Kenneth Clarke

I do not think I rejected Enthoven. Bear in mind that, post 1987, third-term Thatcher finally turned to the public services. First-term Thatcher was saving the country from crisis and bringing it back onto its feet – back to solvency and various other things. The second term was economic and structural reform and privatisation. I do not remember this plan being set out but, if you look at this as how she did go about it, in her third term she finally decided that, in terms of these public services, which were driving her up the wall because of the controversy they caused and the politics they caused – the big public services such as education and health in particular – it was time to tackle

those. She did education first and she had great rows with Ken Baker.[64] When I used to complain about these rows, Richard Wilson used to say, 'You should have been here when Ken Baker was here.'

It was the same thing. It was more autonomy for schools and getting them out of the dead hand of the local authorities: grant-maintained schools, making them stand on their own as autonomous bodies. What we were all interested in was outputs and user pressure, so you were going to be responsive to parents, not to bureaucracy. In the health service, you were going to be responsive to patients, not just to the trade unions and the management of the health authorities. There was, then, some read-across. If you tell me that I, as it were, denied Enthoven, I was in a mood for comparing it with what we were doing in education, and do not forget that I went on to that afterwards. The Department had succeeded in putting Ken Baker's reforms in the cupboard, apart from what they say were early, experimental attempts at it, and I had to get them out of the cupboard and get them going again. You may have interviewed me when I was at Education, but there was a read-across between the two.

Nicholas Timmins

It was more than [that]. David Willetts once called 1982 the Tories' *annus mirabilis* because health, education, housing and community care were all versions of a purchaser-provider split. There were various introductions of market-like mechanisms across public services.

Professor Marshall Marinker

I am just reflecting, listening to what has been going on for the last hour or so, on the enormous difference between this language about health governance and what was going on in my bit of the profession – general practice. It was a time of enormous renaissance for general practitioners. We had emerged from pretty dark ages and we were very self-confident. We had departments of general practice in most medical schools, but more importantly we had a language and philosophy that seemed to clash with that coming from management and government. It was at this point that I set up my own small think-tank whose members included David Willetts, Cyril Chantler, Alan Maynard, Geoffrey Rivett and Charles George.[65] [66] [67] [68] We were discussing all these things and trying, in some way, to relate them to what was going on in the medical professions, because there was enormous pushback to a lot of this talk.

In response to the White Paper Working for Patients, I recall Alistair Donald, a wonderful GP from Edinburgh who was our president [of the Royal College of General Practitioners] saying, 'Before all this, if I said to my patient, "Look, this operation really is not in your best interests", my patient would absolutely have trusted me because I was doing that in the name of his or her health.[69] Now if

[64] Kenneth Baker was Secretary of State for Education and Science (1986-1989).

[65] Cyril Chantler was Professor of Paediatric Nephrology (1980-2000) and General Manager (1985-1988) of the United Medical and Dental Schools, Guy's and St Thomas' Hospitals. He was also member of the NHS Policy Board (1989-1995).

[66] Dr Geoffrey Rivett is a General Practitioner by training who worked as a medical civil servant in the DHSS/DH (1972-1992). See Rivett, G. (1998), *From Cradle to Grave: Fifty Years of the NHS*, London: King's Fund.

[67] Charles George was Professor of Clinical Pharmacology at the University of Southampton. He was President of the BMA (2004-2005).

[68] John James later added that he was also a member of this think-tank.

[69] Dr Alistair G. Donald (1926-2005) was a General Practitioner. He was President of the Royal College of General Practitioners (1992-1994).

I say it, there is cash involved.' I remember David Willetts trying to respond to this problem. He said 'Could we not start to talk about competition, not in terms of money but in terms of quality?' That struck me as a very helpful way of breaking into it. We failed, of course, to break into it, as Ken will remember, but we did try.

Kenneth Clarke

The Royal College of General Practitioners was the only royal college receptive to reform.[70] It was a new royal college. It was proudly asserting the status of GPs and, although it resisted quite a lot, it was quite helpful at times and there were supporters of the process in the royal college. The other royal colleges were, without exception, hotbeds of reaction, vested interest and resistance to change, and we suspected that more of the grandees might have to do some more NHS work if this was allowed to go any further [laughter]. On the whole, they were pretty thoroughly unhelpful.

Dr Graham Winyard

There is a danger that we are re-shading the emphasis of *Working for patients*.[71] It did set up the internal market but there is almost nothing about the district health authority in there – just the odd paragraph. It was largely about hospitals. Working Paper 1 was NHS Trusts. As I understand it, it was hard to get stuff in about the role of purchasers, so it was not a really balanced model that came out then. The purchaser work had to be developed later on, but that was not where the thinking was.

Image 11: (Left to right) Nick Bosanquet, John James, Kenneth Clarke, Nick Timmins, Graham Hart and Strachan Heppell.

[70] The Royal College of General Practitioners was created in 1952.

[71] This remark refers to the reforms introduced by the NHS and Community Care Act 1990 following the 1989 *Working for Patients* White Paper. This inaugurated an 'internal market' in the NHS whereby purchasers and providers were 'split' and hospitals could apply for the new status of 'trusts' which afforded more independence. The White Paper was shorter than previous White Papers and required 34 working groups to detail its proposals.

Nicholas Timmins

We talked about the purchaser-provider split, and you are quite right that the White Paper was very much an outline of what was to be done, with a lot of work still to do, but it had the three ideas. It had the idea of the purchaser-provider split, health authorities doing the purchasing, NHS Trusts as more independent, free-standing bodies, GP fundholders and clinical audit. How did that become the particular mix? You could have had a purchaser-provider split organised very differently.[72]

Kenneth Clarke

We just steadily worked it up. There was a little group formed in my private office. I got Duncan Nichol seconded, and my then private secretary.[73] [74] I had various other officials. There was a lady who has now been made a peeress, who was an accountant.

Nicholas Timmins

Sheila Masters.[75]

Kenneth Clarke

I had my little group. There were little groups all over the Department and we were putting this all together. I always say that I sat down and sketched half of it on a notepad on a headland in Galicia when I went for my August holidays and was the missing minister, and they could not find me on the beaches of southern Spain because I was in northwest Spain busily thinking about trying to put together a healthcare system. When the Department came on board – with great respect, there was slight delay – the then Permanent Secretary [Christopher France] began by telling me that it was a frightfully exciting idea but he did not have any staff who were free to work on this because we were so heavily engaged in everything else. He tried that for about a week. Other members of the Department who wanted to be engaged rapidly came onside, so the White Paper evolved in the usual way.

Purchasing is the biggest problem and we never got it right, really. We are bogged down with commissioning groups now. This internal market idea: providers, fine – NHS trusts and so on. Purchasers has been the nightmare all the way through, and it keeps being changed. I will just add that everything had to be done at a tearing rate, because the thing that was on my mind, once we had

[72] Strachan Heppell later added: 'Chapter 1 of 'Working for Patients' makes clear that the focus of the review was not on changing the NHS but on making it better by raising "the performance of all hospitals and GP practices to that of the best". The conclusion of the review was that this "can be done only by delegating responsibility as closely as possible to where health care is delivered to the patient – predominantly to the GP and the local hospital". The chosen means of doing this was more choice for patients; and more satisfaction and reward for those in the NHS who successfully responded to local needs and preferences. The importance of giving more freedom of action at local level was a starting point in the work at DH. How best to achieve this was identified first in hospitals (the idea of self- governing hospitals appeared very early on; they were later given the name of NHS Trusts). The involvement of GPs (as GP fundholders), came later, after Kenneth Clarke returned to DH as Secretary of State for Health. In the review, the development of new funding mechanisms (the purchaser/provider split) followed the strategic choice to delegate more responsibility for decision-taking to the local level, not the other way round.'

[73] Duncan Nichol was Regional General Manager of the Mersey Regional Health Authority (1984-1989) and Chief Executive of the NHS Management Executive (1989-1994).

[74] Kenneth Clarke's Private Secretary was Andrew McKeown, civil servant, DHSS/DH (1976-2000). He is Chair of the Nuffield Trust (2016-).

[75] Sheila Masters is an accountant by training who was seconded from KPMG (then Peat Marwick Mitchell & Co) to the Department of Health as Director of Finance of the NHS Management Executive (1988-1991).

got it agreed, was that we had got to get this damn thing in place well before the next election. Had all of us been running a serious business-like organisation on more rational grounds, we would have said, 'This is a revolution, really, so it is going to take several years to work out and we might try it out in some places.'

I was fixated, rightly or wrongly, with the idea that we were not going to fight an election with all this in the way. It was controversial enough anyway. I aimed, then, to get in place a working beginning – something that would not collapse and something that would get it underway – but I always envisaged that we would make pigs' ears of bits of it and that it would then start being evolved, which is what we had to do with the education reforms. What you cannot do is fight an election on a plan. If you remember, the things we were accused of, like making people pay to go to their GP. If you do not have it in place, people will believe all this rubbish. Once it is there, at least they can only attack you for what you have done, but it did mean that we all went at a galloping rate and the White Paper was rather thin.

Sir Graham Hart

I will quote you on that: it was rather thin, Ken. What happened so far as the Department was concerned was that we saw the final draft *Working for Patients* a week or something before the great launch, which was itself a tremendous innovation.[76] I do not think that, at the time, one recognised the significance of it because not only was it a PR [Public Relations] triumph, you might think – it was certainly new to everybody – but it was a very strongly signalled commitment by ministers to sell this idea in the NHS, because we realised that this was a huge culture change that was going to be expected of people and there was going to be a lot of resistance or at least puzzlement about it, and it had to be put very strongly to people that not only was this what was going to happen but that it was going to happen. With the help of officials, Ken got this tremendous PR exercise going at the end of January '89.

I remember sitting in my office around that time and writing down, on a blank sheet of paper, the issues that it seemed to me needed to be addressed to build on this, as you say, rather thin document.

Kenneth Clarke

If we had not got it out, you would not have sat down and done that. [Laughter]

Sir Graham Hart

It was classically what was required.

Kenneth Clarke

My view is that this is true of the whole history of the NHS: it always resists change. Every reform, starting with Lloyd George's panel doctors, has met highly politicised resistance. I always cheer up the current Secretary of State by usually saying to him or her, 'You are going to be the most unpopular political figure in the country for as long as you are in this office. Your opponents specialise in personally reviling the Secretary of State.' They did it with Lloyd George and they did it with Nye

[76] This is a reference to the video launch across the UK of the *Working for Patients* White Paper (Department of Health (1989), *Working for Patients,* Cm. 555, London: HMSO). A fifteen-minute film, that included a statement from Margaret Thatcher, was shown to health service managers on the day of the publication (31 January 1989). It was later broadcast on BBC and ITN news programmes. See Margaret Thatcher Foundation website: https://www.margaretthatcher.org/document/107565

Bevan.[77] [78] The only ones who have not been reviled are the completely useless ones who have done damn all but sit there and try to get more money. Anticipating all this, given the background of Margaret being in this state about the two years of hell she had gone through before she had finally committed to the reform, and it is slightly my own combative approach to these things, the idea that, all the way through, I had determinedly got to sell this and get on with it and get something in place, and just make it obvious we were going to do it and we were not going to be stopped, was undoubtedly what caused the appalling problems for everybody around me in the Department trying to keep the show on the road and was my driving motive.

Nicholas Timmins

There is one other thing about the review. Although there were all the influences, like the Cumberland [Lodge] conference and the people Margaret was talking to, such as Willetts, it was a government review. The one bunch of people who were not consulted at any point on the way through was the BMA.

Kenneth Clarke

They were defending Keith Joseph's McKinsey reforms. As a whip on the Bill at the time, I had witnessed the bitter opposition of the BMA to the system of management which they were now dying in the ditch to defend against my wickedly right-wing attempts to undermine McKinsey's devoutly socialist approach to running the whole service. [Laughter]

Nicholas Timmins

How are you doing, John?

Dr John Marks

I am enjoying this – nothing like being an aggressophobe. [Laughter]

Bob Nicholls

It is right in a way but this sums it up. I am pretty old, so I have been through many reforms, but they did not start, really, until '74. Each was preceded by grey books, McKinsey reports, reviews, green papers and consultations. Ken and I had had fun when he was minister over things like supplies, re-organisation so I thought I knew you well enough to challenge at least the pace of the reforms. You had a cold, the very day it had gone through Parliament. You came to St Ermin's Hotel. Fourteen regional managers were sat round the table. This must be in '89 – it was before the big Queen Elizabeth teleconferences. Ken comes back from the House and, despite his cold, you were quite ebullient. You asked the regional managers, 'How are we going to get this done, being an unfinished report?' One or two, 'Gosh, really?'

Image 12: Bob Nicholls

[77] Lloyd George (1863-1945) was the Liberal politician architect for the introduction of National Health Insurance in 1911, which gave most working men access to primary health care through a 'panel doctor'.

[78] Aneurin Bevan (1897-1960) was the Labour politician and Minister of Health (1945-1951) who oversaw the inauguration of the NHS in 1948.

ideas. We went round. I was about eleven out of fourteen and I thought, 'Typical of my colleagues. Pretty sycophantic: "Yes, we are up for it. We can do it"' and I was the Oxford regional manager and we were great believers in Archie Cochrane, in randomised-control trials.[79] I thought, 'I know Ken. I shall have a bit of a go.'

When you got to me, I said, 'It is very interesting and exciting etc.,' but Enthoven had said, '[Do] a few pilots – try this – particularly the GP fundholding'.[80] I thought more devolution to trusts was OK, but GP fundholders? Why are they not looking after patients? I had good GPs in Oxford and I was pretty confident that my GPs would be up for things, so I said, 'What about a randomised control trial?' You savaged me and it was the first time I heard the NHS was like a tanker that takes six miles to even change direction. Much to the amusement, I must say, of all my regional colleagues, I had said that there might be a different way of implementing the reforms.

What was useful about this was that it was political too; if not, and if we had had green papers and consultations with the colleges, you would have just been up to the big rows about it coming into the election.

Kenneth Clarke

It would have wrecked it. I resisted pilots. The BMA's line was pilots. I thought they would wreck the pilots, and their members would make sure that this whole idea was going to be completely beached. As you say, the imperative was to get on with it and do it. Margaret was trying to get me to ditch it before we had implemented it. She lost her nerve about six months previously. I used to use the regional health authority chairmen.[81] We used to describe ourselves as my health cabinet because, by and large, they were all up for it and they knew more than I did about how to implement it and sell it locally, and we used them a lot. All this about pilots, which are very sensible in a sane world, but medical politics is not a sane world. It would have been left wrecked on a beach somewhere, tried out in a part of the South West or something.

Nicholas Timmins

We are nearly halfway and now straying into territory for the second bit, so I would like to stop the story there for a moment. Just coming back to the fact that there was no green paper and it went straight to a white paper.

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[79] Dr Archibald (Archie) Cochrane (1909-1988) was a doctor and epidemiologist who pioneered randomised control trials. Cochrane, A.L. (1972), *Effectiveness and Efficiency in Medical Care: Random Reflections on Health Services*, Oxford: Nuffield Provincial Hospitals Trust; see also Mackillop, E; Sheard S. and Lambert M, (2018) *The Development of Health Economics and the Role of the University of York*, Liverpool: Department of Public Health and Policy, University of Liverpool.

[80] Strachan Heppell later added on pilots: 'The timetable for the NHS review was tight, because the Government wanted to complete it, bring forward proposals and put them into effect as part of an overall plan for strengthening the NHS through reform and extra money. Introducing pilots into the process would have meant a much longer timetable and hence delayed the help the NHS badly needed. Having said that, the way the reforms were introduced, inviting prospective NHS Trusts and GP fundholders to apply to be trusts or fundholders, was arguably not all that different in practice from learning from pilot studies. It enabled lessons to be learned and applied as the reforms were rolled out across the country.'

[81] Fourteen regional health authorities [RHAs] were created by the 1973 NHS Reorganisation Act with various remits such as strategic planning and allocation of resources. They replaced the fourteen regional hospital boards and were abolished in 1996. See Begley, P.; Sheard S, and Mackillop E., (2017) *The 1974 NHS Reorganisation: A witness seminar held on 9 November at the University of Liverpool in London*, Liverpool: Department of Public Health and Policy, University of Liverpool.

Kenneth Clarke

Nowadays, the lawyers would have taken us to court.

Nicholas Timmins

There was no consultation with the BMA or the colleges about what was going to be in it, was there?[82]

Kenneth Clarke

No, not really. I knew what their views were. [Laughter]

Nicholas Timmins

Why not?

Kenneth Clarke

They would have been against it. They were campaigning against the whole idea.

Sir Terence English

I was President of the College of Surgeons from '89 to '92. I had had a wonderful experience of the health service up until that time, from the very beginning. Then I went to see the Treasurer at Cambridge, because he wanted to know what our work was costing and he had absolutely no protocols with this. He got very excited when we got together and I was able to tell him what everything was costing. Eventually, with the Supra-Regional Services Advisory Group, which was a wonderful scheme that meant that Britain controlled the development of its transplant programmes and funded them until they came up to capacity and then created another, this was unique in the world, because transplant programmes were popping up all over the place.[83] From my point of view, the health service was a wonderful thing to work for.

Image 13: Terence English

Then Ken's assault on the medical colleges comes as no surprise at all, but listening this afternoon to the absolute chaos and shenanigans that were going on politically that led up to the reforms comes as little surprise. We tried to discuss this with him as heads of colleges. We used to meet regularly. We thought that it would be a good idea to pilot some of his reforms, which he really gave us very little information about, but that was rejected and he really never wanted to get into discussion with the colleges, and I think he has more or less just admitted it.

What I came to resent most of all about his watch was when, at the time of introducing the Clinical Standards Advisory Group [CSAG], he tried to split the colleges from the BMA, and he did this

[82] This is a reference to the nineteen medical royal colleges in the UK, a number of them had usually been consulted by Government before a health reform.

[83] The Supra-Regional Services Advisory Group was set up in 1983 to advise on specialised services. It was replaced by the National Specialist Commissioning Advisory Group in 1996.

because he wanted to exclude Tony Grabham from the CSAG.[84] [85] He was a strong BMA man, so I thought this was unfair and I asked to see Ken. He was gracious enough to receive me at the Houses of Parliament and I presented it to him. I said, 'Look, this is not right', and he said, 'Grabham was the toughest negotiator I have ever had to deal with. I am not having him in the CSAG'. [Laughter] I went away and wrote to him, saying, 'You establish this thing but the College of Surgeons will absolutely not be part of it, and some of the other colleges will not either.' We won that, Ken, because you agreed on a compromise and said, 'Grabham can come but he cannot vote'. That is all we wanted: for him to be there. This was the sort of stuff that we were dealing with when you were Secretary of State, my friend. Thank you.

Kenneth Clarke

I got on quite well with Tony Grabham but, at his very first meeting with me, he told me at great length about how he had reduced Barbara Castle to tears, just to put me at ease in negotiating with him.[86] [Laughter] He had a very similar temperament to mine, so you can imagine what negotiations between the two of us were often like. He told me it would be perfectly alright, so long as I made a concession to him once a year, because he and the BMA had to get some improvements to their pay and terms and conditions annually. He did not offer peace but we could proceed in an altogether more civilised way if that was done, and he got very cross when I did not do that.

Image 14: Kenneth Clarke and Strachan Heppell.

Nicholas Timmins

I am going to break now, unless there is anything you want covered, Sally, that we have not covered.

Professor Sally Sheard

The one thing I would like to hear just a little more about is the role that economists played at this stage. We have heard about Enthoven but we have not really heard about Maynard or the York group, so could we just have a quick reflection?[87]

[84] As part of the NHS Community Care Act 1990, a Clinical Standards Advisory Group was created to advise health ministers and the NHS on clinical care standards, access and availability.

[85] Tony Grabham (1930-2015) was Chairman of the BMA Council (1979-1984), President of the BMA (2002-2003) and Chairman of the Joint Consultants Committee (1984-1990).

[86] Barbara Castle (1910-2002) was a Labour politician and Secretary of State for Health and Social Services (1974-1976).

[87] John James later added here that '[i]t is worth mentioning that, within the Department, the Economic Division had rather fallen out of favour with Ministers in the late 1980s, mainly I think because they were frank with their advice. In my last two PES [Public Expenditure Survey] rounds, I included a brief from them on what issues of a general economic nature might be important to the Treasury and how their overall stance might be affected. I believe

Sir Graham Hart

They played no part at all.

Strachan Heppell

I wrote a note that I have given to Sally Sheard about how the review was managed, which can be written into the record. Within DH, we had a small group that worked up papers.[88] We kept producing a cycle of papers for the ministerial group at regular (two to three week) intervals. The initial focus – or the way through, as we saw it – was twofold: one was to try to provide more choice for patients; the other was to delegate as much as possible of the real decision-making on healthcare down to hospitals. It was the hospitals that we were focusing on at the beginning because that is where all the financial pressures were. Those two key objectives came first; the funding mechanisms came second – it was not the other way round.

When we were working on this in the group, we did have economists from the Department involved. Jeremy Hurst, for example, who is here today. We had Graham Winyard in the group and always had medical input there. So, economists and doctors were involved in the work of producing the papers for ministers. No management consultants were involved. The first half of the review concentrated on hospitals, and primary care did not really come into it until Kenneth Clarke came back to the Department[89] ; from then on primary care was involved and the idea of GP fundholders was added to the mix.

Nicholas Timmins

There are two bits here that are worth trying to sort out, in the sense that Marshall, Nick and Alan Maynard are all talking about various forms of fundholding – whatever you want to call it – at an external, academic level. Ken is sitting on his headland in Pontevedra. At what point did GP fundholding come into the Department's work and from what source?

Strachan Heppell

It came in from Ken, when he came back from birdwatching.

Nicholas Timmins

The Department, then, had not been talking to Maynard or to Nick. Did the Department talk to you in any of this?

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that Ken and his Ministers of State found these helpful, and thereafter the internal economists were more warmly regarded.'

[88] Strachan Heppell later added: 'To carry out the work in DH, we set up a small team led by an Assistant Secretary, David Clark. The team, which included doctors and economists but not management consultants, was mainly made up of administrators and worked to me. We produced proposals for DH Ministers to consider. When proposals were agreed, we prepared papers setting them out for consideration and approval by a Ministerial Committee chaired by the Prime Minister. To ensure coordination across the Government, each paper put to the Ministerial Committee was first seen and agreed by a small steering group of senior officials led by the Cabinet Office: three Deputy Secretaries from Cabinet Office, Treasury and DH – Richard Wilson, Hayden Phillips and Strachan Heppell - plus two or three others; usually Dick Saunders, an Assistant Secretary from the Treasury, David Clark from DH and John O'Sullivan the No.10 policy adviser. The Ministerial Committee met regularly (each two to three weeks) and took all the major decisions set out in 'Working for Patients'.'

[89] Kenneth Clarke MP was Minister for Health in the DHSS (1982-1985) and returned to DH as Secretary of State for Health (1988-1990).

Professor Nick Bosanquet

They did. One figure we should not forget about – and he has been mentioned briefly – is Mike Lillywhite, who was a really strong reformer within the Department. With Brenda Leese, I had worked with him on introducing incentives for getting coverage for cervical smears and mammography.[90] Before that, you paid for getting an individual check but you spent a lot of money and you did not get the coverage, so we introduced the coverage, and Ken and the Department were very keen on that and introduced it as part of the new contract. That really worked in the 1990s, so there was an interest in the Department in new ideas.

Strachan Heppell

I was recording what actually happened in the reform process, and the GP fundholder did not come into it until Ken came back from birdwatching in Spain. He said, 'Yes, we will have that', so we did.

Kenneth Clarke

What we were having to work out was the fact that we had competition and choice, and we had purchaser-provider, but that was about as much detail as we had. What I was thinking about in Galicia was – and this came up over and over again, long after I'd gone – was exactly who is going to purchase this? You cannot have individual patients because they do not have the clinical expertise. The GP is meant to be their expert guide and their personal physician. If you give a good GP sufficient motivation and incentive – the goods ones would be motivated just by the interest of it – they will want to buy the best value for money in terms of output for their patient.

I do not think that I devised GP fundholding – it may have been kicking around all over the place – but when I came back with whatever I had written about purchasing, somebody somewhere in the Department said, 'There is this idea of GP fundholders.' The reason it worked otherwise was that this was bound to be opposed like crazy. Every GP was going to be attacked by all their colleagues if they cooperated with this dangerous nonsense, so we made it voluntary. We also made the budgets a bit generous, so they were strictly charged that any profit they made had to be put back into the service. The way in which they chose to do that, however, was left entirely to them.

All the more go-ahead GPs steadily started opting to go for GP fundholding, which was a real problem for our opponent, because volunteers, once they are volunteers, burn their boats and then become salesmen for what you are doing. They ignore their trade union telling them that they are betraying their cause and that they should not do it, just like NHS trusts. You get them to volunteer to be the providers, and their reactionary colleagues are not able to shoot them down. After a bit, the whole damn lot became NHS trusts and the whole damn lot would have become GP fundholders, if it had not been abolished by Frank Dobson.[91]

Nicholas Timmins

I am going to stop there, because that is well into the next bit of territory.

[90]Brenda Leese is an economist and co-author with Professor Nick Bosanquet publications on applying economics to health care issues. See Bosanquet, N. and Leese, B. (1989), *Family Doctors and Economic Incentives*, Aldershot, Dartmouth Publishing.

[91] Frank Dobson is a Labour politician and was Secretary of State for Health (1997-1999).

Image 15: (Left to right): Jonathan Shapiro, Kenneth Jarold, Kenneth Clarke, Nick Timmins, Graham Hart, Graham Winyard and John Marks.

[Meeting adjourned]

Nicholas Timmins

Before I give John Marks a go in just a moment, I just want to backtrack slightly on some of the earlier stuff. A number of DH civil servants were dispatched to the US around about this time. Is that right?

John James

I do not know.

Nicholas Timmins

Jeremy Hurst has joined us to talk about the role of economists and analysts in developing these ideas.

Jeremy Hurst

I am a former senior economic adviser in the Department of Health. I was sent to the US in 1989-90 and stayed for nine months. I also went to Canada. That was for the prior group that you have, no doubt, discussed: the working party on finance for the NHS – I have forgotten the exact title.[92] I wrote a report that got fed into that review. I also met Alain Enthoven and I was extremely fired up about his ideas on reforming the American health care system. I have no doubt that you have discussed his role in *Working for Patients*.[93]

[92] See footnote 6.

[93] Strachan Heppell later added: 'As usual with policy reviews, experience in other countries (including other European countries, other Commonwealth countries and the USA) was studied. For example, we visited the Netherlands to look first hand at the outcome of the Dekker Commission on health care, which had recently reported. Such experience can only take you so far, however, as each national situation is different. Grafting ideas from other countries onto the UK system is not straightforward, whether for social security or health.'

Nicholas Timmins

Did you go there after the White Paper, or do you mean 1979-80?

Jeremy Hurst

Sorry, I mean 1979-80.

Nicholas Timmins

That fed into the working party on alternative finance that ended up going nowhere – the one that Fowler binned.

Jeremy Hurst

Yes.

Nicholas Timmins

In terms of working up the ideas that ended up in *Working for Patients*, were the Department's analysts and economists much involved in that?

Jeremy Hurst

Yes, extremely involved under Strachan Heppell's chairmanship of a committee which, to my understanding, was acting as a secretariat for the Prime Minister's committee.[94]

Image 16: Strachan Heppell

Strachan Heppell

Yes, we produced the papers for the Prime Minister's committee.

Jeremy Hurst

There were, in a sense, four economists on that: myself and three colleagues.[95] They might not have sat in on the meetings but they were very much preparing the papers. We were doing our best to try to feed some ideas to the group. A colleague of mine, Michael Parsonage, who was then at the Treasury, was also involved, because he and I were asked to jointly write a paper on a capital-charging system in the new arrangements.[96] He reminded me just the other day that the work of the Prime Minister's committee was essentially a game of two halves. The first half returned to the subject of alternative financing, and the second half latched on to *Working for Patients*.

[94] John James later added: 'Strachan of course appreciated the economists' contributions but Ministers less so.'

[95] The three economists were Valerie Brasse, Andrew Burchell and Nick Jennett.

[96] Mike Parsonage was an economist based in the DHSS Economic Advisers' Office (EAO) (1977-1986; 1989-1992) and the Treasury (1986-1989).

Nicholas Timmins

We get to the launch of *Working for Patients*, on which you spent £1 million and a boat trip down the Thames.

Kenneth Clarke

I do not remember the boat trip down the Thames. We held a press conference around the country simultaneously – a very crude link-up compared with today's modern technology.

Nicholas Timmins

You went on a riverboat to Limehouse.

Kenneth Clarke

Did I really? What was the name of our marvellous press secretary? Was it Romola's idea?[97] I am not into new technology, so none of this was my idea, but I was receptive to it. Whoever arranged it, it was, by the standards of the time, a very hi-tech, whizz-kid presentation. It got, therefore, an extremely good reception on the first day. Astonishingly, we got really quite good write-ups. I remember Margaret thought it was marvellous and embarrassed me by commending it at the beginning of a Cabinet meeting on how to present policy. Of course, with the greatest dismay, I expressed my opinion that I did not think it would last more than five minutes and I hoped she was braced for having the political battle to end all battles before we got any of this implemented, which she thought was a curious reaction on my part. I think she thought we had solved the whole thing by this presentation. I greatly enjoyed it and I have pictures of it somewhere, although, by today's standards, it was comparatively primitive.

Nicholas Timmins

Before I let John in, can I offer you a quote from your press conference launching this thing? [Laughter] You said, 'The BMA, in my unbiased opinion, has never been in favour of any change of any kind on any subject whatsoever, for as long as anyone can remember'.

Kenneth Clarke

It is still a view I hold.

Dr John Marks

I assume you are doing this bit and the next bit separately; in other words, the implementation. I would like to remind Kenneth Clarke of his relationship with the RCGP [Royal College of General Practitioners]. At the presidential dinner, he made a speech in which he said, 'Why is it that, whenever I speak about reform, GPs reach for their wallet?'

Kenneth Clarke

I thought it was quite witty. It was a disastrous mistake for the last thirty years.

[97] Romola Christopherson (1939-2003) was Director of Information, then of Press and Publicity for the DHSS/DH 1986-1998, and Associate Director Media Strategy 1999-2002.

Dr John Marks

It was not an accident – he had prepared it. I can assure you that all the health bodies – the colleges, the GPs, the BMA and the nurses – were shattered not to see the terms of reference of the working party, not to be invited to submit evidence to it, and not to be invited to submit names for consideration as members. I was a member of Keith Joseph's working party when we devised the up and down, which Kenneth Clarke referred to before.[98]

Image 17: John Marks

As far as the BMA is concerned, we believed that the problem was Kenneth's obsession with the BMA. I am going to quote an article from *The Economist* which everyone has been talking about, because it does it so much better than I could: 'Ten years earlier' – that is, in 1979 – 'the BMA could not have taken on any government let alone an ideologically self-confident one like Mrs Thatcher's.[99] The BMA was known to the public' – and, I suspect, to the Department as well – 'as the British Money Association and its membership halved. It then made a deliberate decision to revamp its image, with well-publicised campaigns on smoking, drinking and driving with seatbelts. It built up a strong relationship with the general public and its patients. Its membership rose to three-quarters of the entire profession.'

The Economist did not notice, of course, at the time that the leadership changed in 1979. Tony Grabham became chairman of the Council and I became deputy chairman of the representative body, which is the doctors' parliament. By the time this affair started, Tony Grabham was the chairman of the Joint Consultants' Committee and I was chairman of the BMA. We, of course, were products of the NHS. I qualified the day it started, so I know all about the NHS.

The article continues: 'Mr Clarke appears not to have noticed this revival when he set out on his campaign. His campaign – which was intended to pick out the leaders of the medical profession in small groups, isolate the BMA as the voice of the wallet-conscious backwoodsmen and win the support of the royal colleges – was pitched at the BMA of 1979 and not the BMA of 1989.'

Nicholas Timmins

John, that is all very well but you spent £3 million and more on posters on Mrs Thatcher's plans for the NHS.

Dr John Marks

I will come on to that.

Nicholas Timmins

That was hardly what you would call cooperation.

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[98] A reference to 1974 NHR reorganisation principle of 'accountability upwards, delegation downwards'.

[99] 'Dangerous Doctors', *The Economist,* 19 August 1979.

Dr John Marks

I will come on to that in the next issue.

Nicholas Timmins

We are talking about implementation.

Dr John Marks

It was not implemented. At this stage, it had not been implemented. We are dealing with why the stakeholders were not asked. The other thing comes under: why were there no pilots? That is what our thing is about. They are two separate issues, as far as I am concerned, and I cannot confuse them for myself.

Nicholas Timmins

We have covered, at some length, the fact that the professions were excluded from this exercise. We have heard a load of reasons why and I can understand the professions were very cross about that, but that is what happened. We get to the implementation stage and it turns into all-out war.

Dr John Marks

There is one question that you could answer. You said that he told you the one thing we had to do was to knock them off their pedestal. 'We had to pull them into the mud with us' – your words, not mine – and he failed.

Nicholas Timmins

You had this big launch and you had the bare bones and loads of additional working papers to work out how it is going to work. This might amuse you, but I remember the press conference where it was done and we said, 'How many NHS trusts are you likely to get and do you need, and how many GP fundholders are you likely to get and do you need, to make this credible?' The health correspondents from *The Independent*, *The Times* and *The Guardian* tried to open a book on it but we could not because we all agreed that you would probably get ten self-governing hospitals and you might get twenty GP practices, but you ended up with 140 applications for NHS trusts.

Kenneth Clarke

The numbers rapidly grew. Once we had got the first few, it started swelling quite rapidly. I thought they would encounter ferocious hostility from their co-professionals when they did it.

Nicholas Timmins

There was a conversation between you and Graham at the very end. You refused to have pilots. There was a dinner with you and John Havard and Ken.[100]

Dr John Marks

I will talk about that in the second half, if I may.

[100] John Havard (1924-2009) was Secretary of the BMA (1980-1989).

Nicholas Timmins

This is the second half.

Dr John Marks

During the spring of 1989, there was overwhelming evidence that the vast majority of doctors in the UK were opposed to this. One of the most outspoken critics was Sir Henry Yellowlees, who had been the Deputy Chief Medical Officer and then the Chief Medical Officer.[101] He was an elected member of the BMA Council. Arnold Elton, who was then the President of the Conservative Medical Society, got very worried about the effect we were having on the Tory party's image.[102] He arranged a private dinner and had three guests: Kenneth Clarke, John Havard, who was then the BMA Secretary, and John Marks. After an excellent meal, I asked Kenneth Clarke to have a properly audited pilot, as Enthoven had said in his paper. His response to me was, 'You buggers would sabotage it' and I got up and walked out. He knew that I had been on Keith Joseph's working party and he knew that I had put my medico-political career on the line by getting it through the BMA against the wishes of the establishment, so my record is quite clear.

I could not deal with such bigotry – I just cannot deal with that. The following morning, advertising and propaganda took off. It was described as 'of memorable brilliance' by one Nick Timmins. [Laughter]

Nicholas Timmins

It was.

Dr John Marks

In July, a Gallup poll showed that 73 per cent of the population agreed with us.[103] Kenneth Clarke's response was, 'Three out of four people in this country are mistaken and plainly have not understood

Image 18: Kenneth Clarke, Nick Timmins and Graham Hart.

[101] Henry Yellowlees (1919-2006) was Chief Medical Officer in the DHSS (1973-1983).

[102] Arnold Elton is a consultant surgeon and was President of the Conservative Medical Society (1992-1997).

[103] The poll was cited in *The Times*, 'More against health reform', 18 April 1990. See Marks, J. (2011), 'The End of the NHS?', *British Journal of General Practitioners*, 61(685): 290.

the reforms', but he had to admit later to *The Guardian* that 70 per cent of the population thought we were winning. In 1990, Mrs Thatcher sent David Willetts, Lord Rayner and Robin Ibbs to make an assessment as to whether the reforms would work.[104] [105] They said they would not. According to Nick Timmins [quoting from paper] 'She wanted to scrap the health reforms, put them off or postpone them until after the election. Clarke absolutely refused'.

Nicholas Timmins

Yes.

Kenneth Clarke

It was the Taoiseach – what was his name? A splendid fellow – an old rogue. Charles Haughey.[106] She had a meeting with Charles Haughey when she was getting a bit worried about her election coming up. Charles Haughey completely persuaded her that you could not win an election in our circumstances – the United Kingdom or the Republic of Ireland – if you were fighting the doctors, so the only chance she had, in Charles's opinion, was to stop fighting the doctors and to get rid of this controversy with the doctors. She had this *idée fixe*. She got hold of some of her closest entourage and ordered them to produce a report saying that it was not going to work – which, as you say, I did not agree with – and then we had an extraordinary meeting where the businessmen who usually advised her – some very formidable guys, none of whose names come back now – were all brought in, in order to explain to everybody and to confront me. I went with some of my keenest junior colleagues from the Private Office to face these great men and the Prime Minister at the Cabinet table, and they were going to point out to us, with their business experience, that this was hopeless and could not work.

This was a comic meeting, really, because the businessmen knew nothing about the National Health Service. They plainly agreed that they knew nothing about the National Health Service and they were very untypically diffident in putting forward the views that the Prime Minister had obviously ordered them to put. Their input was a bit patchy and it was a very odd meeting. I wanted to retire from this scene of disputing with the Prime Minister, so I was encouraging my Private Secretary and the others to pipe up and explain to her: 'We have been working on this bloody thing. You explain to her that it is going to be a bit rocky but it is okay.' They were all totally overawed. Looking back, they were all twenty years younger than me and had probably never been in Downing Street in their lives. They were sitting at the Cabinet table facing a somewhat formidable Prime Minister who was expressing quite strong views. To my amazement, there were one or two people I was sitting with for whom I had a very great deal of time but they were all tongue-tied and blushing slightly as they hesitantly gave views. As I ran my Private Office like a debating society, they normally were not inhibited like this, and gave their views.

Then I put the case and the whole thing reached this ludicrous ending, where it was yet another exchange between me and Margaret Thatcher, with a lot of embarrassed businessmen and young civil

[104] Derek Rayner (1926-1998) was Chief Executive of Marks and Spencer's (1983-1988) and adviser to the Prime Minister on improving efficiency and eliminating waste in Government (1979-1983).

[105] Robin Ibbs (1926-2014) was Director of ICI (1976-1980;1982-1988) and was adviser to the Prime Minister on efficiency issues, notably overseeing the introduction of the Next Steps agenda which hived off Whitehall's operational work to new 'quangos'.

[106] Charles Haughey (1925-2006) Taoiseach (Prime Minister of Ireland) (1979-1981; Mar-Dec. 1982; 1987-1992).

servants sitting there, trying to gaze at the ceiling and get the two of us to stop wrangling when she wanted to scrap it. My opinion, apart from my commitment to the whole thing, which I had devoted quite a lot of my time to, was that, if you wished to get a complete political disaster out of this, then by all means spend two and a half years in flaming warfare with your opponents, meanwhile trying to get ready, and then, at the end, pull the plug, say you were wrong and retreat. I could not have carried on but, in my opinion, quite apart from the fact that I would have been thrown to the wolves, plainly, as being responsible for this outrage and this folly of upsetting John Marks and the BMA [laughter], I did not think the Government would do very well out of this either. It would be a bit like the Government's position today: it would look like a complete and utter pig's ear [laughter]. That was the level of argument that Margaret and I were getting to, and all these grave and senior people were sitting around. They were businessmen and I would have taken their advice, but they were not all of that view anyway and they had just been instructed to say that, on the basis of their experience, this was an ill-planned scheme and had not really gone into it. They were not prepared to offer an opinion much.

Nicholas Timmins

That jumps all the way forward to September 1990, with the reforms due to take effect in April 1991. Let us go back a bit to the implementation and something about the launch, Ken.

Ken Jarrold

Image 19: Ken Jarrold

It is really important to understand how powerful that launch was. I attended one of the regional meetings that had the message beamed over to us, and it was the first time in my career – and I had been involved in the service since 1969, so quite a long time – that I had ever had an experience of that kind. Not only was the Secretary of State in his normal fluent, combative form but sitting beside him was Duncan Nichol, which was very important to managers, because Duncan Nichol was our man from the managerial community. We were really proud to have one of ours as the Chief Executive of the [NHS] Management Executive, and to see the two of you together totally committed to this was a very powerful thing.

We then had very good quality packs of information, which Romola had presumably organised in her inimitable fashion, to take back to our health authorities. [Graham Winyard brandishes the information pack] I well remember running these meetings with this wonderful material available, telling people about these reforms. Just a little note about fundholding: the opposition to fundholding was at its height, but it intrigued me that, when I had done my spiel and the meeting was over, one of the most senior and respected GPs in Gloucester sidled up to me and said, 'How do I find out more about fundholding?' [Laughter] I knew then it was going to appeal to a very important section of general practice, so the launch was a very significant moment in the history of the NHS.

Kenneth Clarke

It was nothing to do with me – I just had a walk-on part. I had to be persuaded to do it. It had never occurred to me. Presenting was quite a new thing. I had had attempts to present things before. I was

the partner in crime of David Young in Employment in DTI [Department for Trade and Industry] when we were introducing Action for Jobs, National Vocational Qualifications and all kinds of things.[107] We set out to sell our policies. David had a private-sector background and was much more used to public relations. We had a hell of a job persuading the Cabinet Office and the Cabinet Secretary to let us do any of this at all: the idea that the Government was going to have advertisements and the idea that the White Paper might have pictures in it. We were lectured severely about not understanding the standards of public life. All the cover was supposed to have was a little royal coat of arms and black letters. I had that background but it was somebody else's idea to make this extraordinary leap into this nationwide linkup, which the previous Cabinet Secretary would have had forty fits about this salesmanship of a policy.

Dr Graham Winyard

I discovered this in the bottom of a cupboard. I am bequeathing it to Sally for the archive. It is the staff communication pack. It has pamphlets, overheads and a videocassette. It reminded me of a hilarious meeting in Graham [Hart]'s office shortly before the launch, when we were all getting a bit worried about the impact of the first section of the video, which was the Prime Minister in full flood. Graham wondered if we could get a message out that it could be fast-forwarded to have a better effect. [Laughter]

Dr John Marks

Out of the blue, a copy of this arrived on my desk the weekend before the Great Monday. I read it and I showed it to my colleagues, and we all thought it was a hoax. [Laughter]

Bob Nicholls

On Ken Jarrold's point about the launch, Ken and I had that dialogue at the St Ermin's Hotel and me being squashed and wanting pilots and all these reasonable things. You [Ken] said in your book and again today that, without general management and the cabinet of regional chairs, which Virginia Bottomley used later, if you got the regional chairmen on board, and our man, Duncan, the chief executive, on board, with Griffiths' general management, unless you wanted to resign and join John [Marks] and the protests in the streets, that was your job. There was also a performance review. Some of these things had come in post Griffiths before these major reforms.

I had just changed chairmen from Gordon Roberts – trade union background and a trusted diplomat – to a senior businessman with a tough reputation. Gordon had appointed me to take over as general manager from Rosemary Rue for the Oxford region.[108] [109] He appointed me, presumably with Duncan's say-so, and there was a change of chairman to Stuart Burgess.[110] I had been Duncan's boss years before and we are still friends to this day. He rang me up and said, 'Your chairman has a pistol in his briefcase for you. Deliver so many trusts and deliver fundholding. You have all the tools.' I remember the conversation, because I had bought into the purchaser-provider split but I was not at all sure about GP fundholding, which is why I wanted a pilot. Oxford was a small region, and Rosemary had built good relationships. The consultants and hospitals were not that interested in

[107] David Young was Secretary of State for Employment (1985-1987) and for Trade and Industry (1987-1989).

[108] Gordon Roberts was Chairman of the Oxford Regional Health Authority (RHA) (1978-1990), Chairman of the Supervisory Board of the NHS Management Advisory Service (1982-1985) and of the RHA Chairmen (1982-1984).

[109] Rosemary Rue (1928-2004) was a General Practitioner and medical administrator who was Regional General Manager (1984-1988) and Regional Medical Officer (1973-1988) of the Oxford Regional Health Authority.

[110] Stuart Burgess was Chairman of the Oxford Regional Health Authority (1990-1994).

becoming NHS trusts, except the elective Nuffield Orthopaedic Centre, which was elective-only. At the end of year one, I was bottom of the league table for trusts won. Luckily – and I have talked to Marshall about this – the terrific GPs in Oxford were queuing up. I did two good things: the finance director was brought into it, and I happened to have a project manager guy straight from the SAS. With the finance guy, the SAS man and quality GPs, we were easily top of the league at the end of year one and my job just about survived. I say it as a joke, but it felt very serious at the time!

Nicholas Timmins

It is a really important point. Without general managers, this would not have happened, because loads of those first-wave trusts were put forward by their general managers, sometimes in the teeth of opposition from their consultants.

Kenneth Clarke

The regional set-up was very important. I appointed businessmen, some of whom were pretty tough, but they were also keen. They were generally well motivated. I have already said that Duncan Nichol played a very big part in delivering the whole thing. I have not seen him for a long time. He was running the King's Fund.[111]

Bob Nicholls

He is Chairman of the Countess of Chester Hospital and still at it.

Kenneth Clarke

Is he really?

Nicholas Timmins

I want to bring in Greg Parston, in a minute. At the end of the last session, you turned to Ken [Clarke] and said you had refused to have pilots. Actually, because these were done in waves, you almost had pilots in practice.

Kenneth Clarke

I agree with you. The fact is we had waves of trusts, in practice. Of course, if any of those had quickly gone belly-up, we would have to have gone back to the drawing board rapidly, so we were piloting, in effect. I was not going to have agreed pilots in some part of the world negotiated with the profession, with two or three years to run the pilot and another two or three to appraise it. That is where the Department for Education thought they had Ken Baker's education reforms, by the time Margaret packed me off from the Department of Health to make less of a row there. She moved me to the Department for Education to start creating a row, get Ken Baker's reforms out of the cupboard and going again.

Nicholas Timmins

If there were no pilots, there was some war gaming, which was the 'Rubber Windmill'. Can you give us three minutes on that, Greg?

[111] Nick Timmins later corrected that Duncan Nichol didn't run the King's Fund but, in the early days when NHS Chief Executive, stayed at the King's Fund College when invited by Gordon Best.

Dr Greg Parston

Sally would do well to look at the appointment of Duncan Nichol. Duncan came on board with Peter Griffiths who, at the time, was leading Guy's.[112] He made a very big difference, as Ken Jarrold said, but Duncan was not the Secretary of State's first choice. It was through the intervention of Gordon Best.[113]

Kenneth Clarke

Duncan was not what?

Dr Greg Parston

He was not the first choice.

Kenneth Clarke

Was he not? I thought he was the chairman of the North West Regional Health Authority.

Dr Greg Parston

He was the regional general manager, RGM.

Kenneth Clarke

He sold me the idea of getting Duncan. Firstly, I did not know that Duncan would accept it, but Don Wilson sold it to me.[114] I do not remember having a choice before it.

Dr Greg Parston

The general manager from a London region was first announced.

Image 20: Greg Parston

Professor Sally Sheard

Do you want to name the person?

Dr Greg Parston

Mike Fairey.[115]

[112] Peter Griffiths was Regional General Manager of South East Thames Regional Health Authority (1988-1989), Chief Executive of Guy's and Lewisham NHS Trust (1991-1994) and Deputy Chief Executive of the NHS Management Executive (1990-1991).

[113] Gordon Best was Director of the King's Fund College (1986-1991).

[114] Donald Wilson (1922-2001) was Chairman of the Mersey Regional Health Authority (RHA) (1982-1993;1993-1994), the West Midlands RHA (1993), and the North Western RHA (1994-1996).

[115] Mike Fairey was Chief Executive of The Royal London Hospital and Associate Community NHS Trust (1991-94).

Nicholas Timmins

He was North East Thames at the time.

Sir Graham Hart

Duncan was a non-executive member of the [NHS] Management Board for a year or two, maybe longer, before Len Peach stepped aside.[116] We had to find a new chief executive for the NHS. I was not involved in the selection process. Mike Fairey was also around; he was an executive member of the NHS Management Board, and a very experienced and good health service manager too. He was from North East Thames originally and all sorts of things before that. I have no knowledge of who was interviewed, but I am sure it was all done – unless the Secretary of State as was tells me otherwise – in the proper format.

Kenneth Clarke

Yes, it was.

Sir Graham Hart

I was involved in the appointment of Duncan's successor, which was handled in a typical civil service appointment manner.

Kenneth Clarke

I do not think we fixed it, because Duncan was a very good candidate. I made my views known, but I would not have overindulged him. If you had presented me with somebody who was plainly designed to be the worst possible critic, who would slow the whole thing down and all the rest of it, I would have had a row. I recalled no problem about appointing Duncan Nichol, and so he may have come through the system and then Don Wilson persuaded me that he would be marvellous. I knew Duncan Nichol, because I was meeting the regional people so regularly. They were my best and most motivated contacts on the ground.

Dr Greg Parston

Duncan was one of the managers and he was theirs, but what was really strong about him was bringing in Peter Griffiths. Peter Griffiths was a hard guy and he drove a lot of this. There was no pilot, but David Willetts called for one at one of the Centre for Policy Studies conferences. A RGM [Regional General Manager] in East Anglia, who we have not mentioned earlier, Alasdair Liddell, whose chairman...[117]

Nicholas Timmins

Colin Walker was the chair; Alasdair was the RGM.

Dr Greg Parston

Colin raised his hand and offered East Anglia as a pilot, at an assembly. That put Alasdair Liddell, who was the RGM there, under the gun. He hired us, the Office for Public Management [OPM], to

[116] Len Peach (1932-2016) was Director of Personnel and Corporate Affairs (1975-1985; 1989-1992) and was seconded to the DHSS as Director of Personnel (1985) and Chief Executive (1986-1989) of the NHS Management Board.

[117] Alasdair Liddell (1949-2012) was Regional General Manager of the East Anglian Regional Health Authority (1988-1994) and Director of Planning, DoH (1994-2000).

begin thinking about how this could all work. Sitting with him on the tarmac in Copenhagen, I remember, he tried to describe the internal market and I said, 'You don't have a clue how this is going to work, do you?' He said no, and so we borrowed a simulation technique that we had developed in Canada for a regional planning exercise. We developed a behavioural simulation called the Rubber Windmill.[118] There are a number of people here who were there. Graham [Winyard] was there; John [James] was there. There were a number who were involved in that, but people played their own real roles. The RGM was an RGM. The district general manager [DGM] was you [John James], at that time. This was in March and April of 1990. It was a three-day simulation, and we had outside people including Tony Culyer from the York economics unit.[119] We had the past president of the New York City Health and Hospitals Corporation [Dr Jo Ivey Boufford]. A number of other people were tweaking it and we pushed it until it broke, because we wanted to see what would make it break.

Mrs Thatcher responded to alarmist news accounts, mostly from David Brindle in the *Guardian*, saying that these are just war games in East Anglia. [Laughter] Ken, in response, you said that, once we got the regulation in place, this would all be just fine. The Rubber Windmill showed three things. One was that we knew nothing about the purchasing side of stuff. It was in complete disarray and it still is, I dare say. There was no way to regulate that around outcomes and, if you could find a way, you could provide a unifying purchasing approach to the providers. What happened was, when the purchasers had to select different strategies, essentially cherry picking, the providers began to tailor their services and you began to get a very different set of offerings.[120]

Nicholas Timmins

Greg, do you think anything changed as a result of that and does anybody else think anything changed?

Kenneth Clarke

It probably helped to excite Margaret's doubts about whether she wanted this to carry on. I have never heard of it.

Dr Greg Parston

It led to a confirmation of the waves and to Peter Griffiths talking about a 'slow take-off', until somebody told him that slow take-offs crash. It began making people see that you had to have some type of control over purchasing in a way that was not there before, and a lot of regions began to develop clear objectives around health outcomes.

Graham Winyard

It was a terrific event. As has been said, it reinforced that we had not got anywhere on purchasing. I would like to look back on the White Paper, but could not find it. My memory was a tiny number of paragraphs that barely scraped in. It was not one of the nine or ten working papers; it became

[118] The 'Rubber Windmill' simulation exercise was commissioned by the East Anglian RHA in 1989 to test the limits of an internal market in the NHS. The exercise concluded with the collapse of the system due to financial and competitive pressures, thus highlighting the need for good management to make the new system work. See Liddell, A. and Parston, G. (1990), 'How the market crashed', *Health Service Journal*, 17 May 1990.

[119] Reference to the Centre for Health Economics at the University of York, UK.

[120] John James later added: 'It may not be clear to future historians reading this that there were further Rubber Windmill events in succeeding years, albeit they were less dramatic from a media perspective.'

something called Project 26. We are jumping ahead, but we involved lots of working groups and, under their auspices, there were major programmes of works, some of the fruits from which we still have today. That meant we got serious about purchasers. A question I will ask later is, 30 years later, if we are still after world-class commissioning and we still cannot do it, there may be a flaw in the concept. That is jumping ahead.

Dr Greg Parston

Can I add one more lesson to that, which is relevant to today? When the Rubber Windmill crashed, when people could not fulfil their contracted obligations as providers, was when money was taken away from local government. Local government could not field the discharges and the acute centre was locked out. That is the problem.

Bob Nicholl

Can I comment on that? I am fascinated to hear Ken say that he did not know about the Rubber Windmill.

Kenneth Clarke

If I did, I have forgotten it.

Ken Jarrold

It had a huge impact on the service and was a very important piece of work. Al Liddell will always be honoured for that, among many other great things that Al did. I have a quote from the Rubber Windmill, which I happened to find before I came today and is exactly what Ken has been saying: 'The capacity of purchasing authorities to achieve a clear identity, involve the public and, by doing so, gain power to hold providers to account is the key to the further stability of the NHS.' That is what has never been achieved. Like Graham, I would love to return to it.

The other thing I would like to put alongside this is the question I have asked every national Finance Director of the NHS I have ever met, which is how do you have an internal market, purchasers, providers and PbR [Payment by Results], within a cash-limited system.[121] Nobody has ever explained to me how you can achieve that, because you do not pay people for the extra work they do. You just fudge it at the end of the year with the amount of money you have. We can discuss purchasing later, but I have never understood how you do it within a cash-limited system.

Kenneth Clarke

You can switch your purchases from one part of the system to another provider in a cash-limited system.

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[121] 'PbR is the payment system in England under which commissioners pay healthcare providers for each patient seen or treated, taking into account the complexity of the patient's healthcare needs. The two fundamental features of PbR are nationally determined currencies and tariffs. Currencies are the unit of healthcare for which a payment is made, and can take a number of forms covering different time periods from an outpatient attendance or a stay in hospital, to a year of care for a long term condition. Tariffs are the set prices paid for each currency.' (NHS (2011), *A simple guide to payments by results*, London: Department of Health). It was implemented across the NHS in 2008.

Ken Jarrold

I am immensely grateful that we have the internal market instead of what Mrs T wanted. If it did nothing else for the NHS, I will always be grateful for that, but I have those doubts alongside Graham's.[122]

Dr Jonathan Shapiro

Image 21: Jonathan Shapiro

At that time, I was just a GP. I became an academic later, but when the reforms were introduced, I was at the receiving end of this without being one of the great and the good, hearing about all this. The perceived problems from general practice were not about the money; they were about the difficulty of referring and the provider dominance. It was the dominance of the hospital. The money was always going to hospitals, so the provider drive was there. In that sense, the idea of having a commissioner who would control it seemed very sensible, but it's hard to start a market when the providers are in place. You should start it with the commissioners and then introduce the providers, so the NHS has always been provider-led and it still remains provider-led to this day.

On pilots, I have two points to make. I have always said that the NHS runs pilots in the NHS for three reasons. One is as a genuine pilot, but that is rare. The second reason is to drive a new idea into the ground and the third is to roll the idea out. It felt like this was a thing being rolled out. The NHS is peopled by very clever folk who know how to game. The first wave was very popular because there was money to be made and, as the money dropped, recruitment became more difficult. It then had to gain on its moral virtues, although some practices did still get some benefits. As a GP who felt the difficulties in referral, the idea of giving me the control was extremely powerful. I was very ambivalent about holding the money for reasons that have come up, but not about actually having responsibility. I was a good GP and I am fairly altruistic, but the perception was that the money would get in the way of the referral decision. I later joined the NACGP [The National Association of

[122] John James added: 'A number of consequences of the internal market were not adequately discussed in the remainder of the event. Among these are: (a) The steady state with which we began; (b) The need for Regional oversight of difficult negotiations once steady state ceased; (c) The arguments over the currency of the market, and notably the disputes over finished consultant episodes, which began following an article by one of my staff in the HSJ [Health Service Journal], and remained a source of contention for years afterwards; (d) The inclusion of London's Postgraduate hospitals that had hitherto been directly funded from DH in the market itself; (e) The central funding to keep Barts and UC [University College London] running when more distant purchasers sought to reduce flows to find cheaper more local suppliers; (f) The work of LIG [London Implementation Group] and the way in which Inner London DHA CEs [Chief Executives], freed of managerial responsibility for their former Trusts, were able to review services on a wider basis, seeking with mixed success to reduce the number of tertiary centres; (g) The evolution towards specialist commissioning at both Regional and National level; (k) Work that continued at both national and regional level through the early to mid-nineties to develop the commissioning expertise and roles.'

Commissioning GPs], the commissioning GPs, which led directly to PCGs [Primary Care Groups], which influenced the decisions without actually holding the money.[123] [124] That was the idea anyway.

Professor Marshall Marinker

I was going to take us back to the warfare that was going on to remind us that it was better. It was Richard Smith, who was then editing the *BMJ* [British Medical Journal], who commissioned a paper from Alan Maynard, Denis Pereira Gray, who was then the College president, and me.[125] [126] [127] [128] Do you remember? You absolutely went berserk [speaking to John Marks]. Not only was this not BMA policy, but it was in the *BMJ* and the MSD Foundation actually sits in the BMA building. It could not have been more subversive.[129]

My abiding memory was what I thought was a shameful meeting of the Council of the Royal College of General Practitioners. Most of the members of the Council were representatives of their faculties, which were geographical areas. There was a motion to reject the White Paper on the grounds that it would damage patients, and all the faculty members arrived at that meeting to have the debate, having been instructed by the faculty board to vote in favour of the motion to turn down the White Paper. Four of us opposed that motion: John Fry, a pioneer of research in general practice; a person whose name will not mean a lot to you, Colin Waine, a GP leader from our North of England Faculty, Douglas Garvie, at the time the College treasurer, and me.[130] We were outed by no less than Julian Tudor Hart, one of the great Marxist thinkers about health services, as the Gang of Four in the next edition of the *BMJ*.[131] [132] As a result of that, after eighteen years on the Council, usually elected first or second, I came bottom of the poll and never got on to the Council again.

Nicholas Timmins

I remember you being accused of being quislings.

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[123] National Association of Commissioning GPs regrouped GPs who were opposed to fundholding and began working collectively at the local level to influence health authorities and their purchasing and planning of services. See House of Commons Library (2016), *NHS Commissioning before April 2013*, Briefing Paper No CBP 05607, London: House of Commons.

[124] In 1999, 481 Primary Care Groups replaced GP fundholding.

[125] Richard Smith was Senior Assistant Editor (1984), Editor and Chief Executive (1991-2004) of the British Medical Journal.

[126] The British Medical Journal has been published since 1840.

[127] Professor Denis Pereira Gray was Chairman of the Council (1987-1990) and President of the Royal College of General Practitioners (1997-2000).

[128] See Gray, D.P.; Marinker, M. and Maynard, A. (1986), 'The doctor, the patient and their contract – I. The general practitioner's contract: why change it?', *BMJ*, 292 (1986), pp. 1313-1315; and (eadem) 'The doctor, the patient and their contract – II. A good practice allowance: is it feasible?', *BMJ*, 292: 1374-1376.

[129] The MSD Foundation Limited for medical education is supported by the pharmaceutical company Merck & Co.

[130] John Fry (1922-1994) was a General Practitioner and a Councillor of the Royal College of General Practitioners.

[131] Julian Tudor Hart is a former General Practitioner and President of Socialist Health Association.

[132] Julian Tudor Hart dubbed the GPs who had supported the reform as 'the gang of four': Denis Pereira Gray, Donald Irvine, Marshall Marinker and Colin Waine. See Rivett, G. (1998), *From Cradle to Grave – Fifty Years of the NHS*, London: The King's Fund.

Professor Marshall Marinker

What is also interesting is that, of that Council, a year later about half the members were fundholders. [Laughter]

Professor Nick Bosanquet

I do not think we should forget that, after the implementation, there was a very powerful move both on trust status and on fundholding. There is no doubt the incentives were seen as very powerful in going both those ways. It was the bottom-up response that really transformed the reforms. We were talking about minor pilot schemes, which were essential. I worked with Stuart Ingham, who was then the Chief Executive of the LGI [Leeds General Infirmary] in Leeds, trying to persuade the consultants to vote for trust status.[133] The message was either vote for trust status or prepare for closure. In fact, they voted very heavily for trust status and were given a big new development as a result. Similarly, fundholders, within five years, 52 per cent of the population was covered by fundholders.

Nicholas Timmins

Yes, but 50 per cent of them were not; they were covered by other commissioning arrangements. It is interesting that all the hospitals became NHS trusts, but that partly goes back to Bob's point. The interest of managers was in forming the future, not in resisting it, so they drove it through. GPs remained divided about it. Those who did not want to become fundholders did other things; they formed other commissioning arrangements and would not become fundholders. That did not get all the way through.

Dr Jonathan Shapiro

Consultants lost a lot of their power base. Chris Ham has a nice story that, before the reforms, the GPs would send consultants Christmas cards in order to win their favour.[134] After fundholding, the consultants would send them to the GPs, so consultants felt that their power base was significantly diminished and presumably the fear of that led to a lot of opposition in the first place.

Kenneth Clarke

Consultants started holding cocktail parties in some of the major hospitals in order to meet the GPs, who they previously had ignored. [Laughter] Their interpretation of the reforms was that they might actually lose some referrals if these chaps were now allowed a choice, so they had better get to know them.

Dr John Marks

I would like to reply to four points that have been raised. Firstly, I was his employer [speaking about Marshall Marinker]. I was a trustee of the Merck Sharp Dohme Foundation, not MSD, the Merck Sharp Dohme Foundation.[135]

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[133] Stuart Ingham was District General Manager of the Leeds Western Health Authority (1988-1990) and Chief Executive of the United Leeds Teaching Hospital NHS Trust (1991-1998).

[134] Chris Ham has been Chief Executive of the King's Fund since 2010. Previously, he was Director of the Health Services Management Centre (1992-2000) and Professor (now Emeritus) of Health Policy and Management, the University of Birmingham (1992-2014).

[135] Professor Marinker later added: 'The MSD Foundation was a charitable trust set up in the mid-1970s. Its purpose was to develop and support the registrar training of general practitioners and their continuing education. Funded by the pharmaceutical company MSD Ltd, its Board of governors was made up of leading figures in the RCGP, BMA,

Professor Marshall Marinker

What is your point?

Dr John Marks

My point is it was a front company.

Professor Marshall Marinker

That is absolute rubbish.

Dr John Marks

Who is MSD?

Professor Marshall Marinker

It was not a front company. It was simply a charitable company.

Dr John Marks

Who funded it?

Professor Marshall Marinker

You were on the board.

Dr John Marks

That is what I was saying.

Professor Marshall Marinker

If it was not a proper charitable trust, what were you doing on the board?

Dr John Marks

It was a charitable trust, but it still linked its name to a major drug firm.

Professor Marshall Marinker

The Nuffield Foundation does too.

Dr John Marks

That is where it got its money from.

Professor Marshall Marinker

The Nuffield Foundation does too.

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the GMC and others concerned with the quality of postgraduate medical education. The first chairman of the Board of Trustees was Sir Douglas Black; later Lord Walton and Sir Donald Irvine, both Presidents of the GMC. Marshall Marinker had left the Foundation Chair of Community Health at Leicester University to take over as Director. Board Members were drawn from RCGP officers and others in public life – Julia Neuberger, Lord Kilmarnock, Lady Fisher. John Marks, then chair of the BMA, was himself a Board member at this time. Following the publication of *Working for Patients* (1989), Marinker had given public support to fundholding in a *BMJ* article.'

Nicholas Timmins

We have had enough of this private grief. Can you move on to the next point?

Dr John Marks

I knew about the Rubber Windmill, because it failed. It was a pilot that failed.

Nicholas Timmins

It was driven to failure was the point.

Dr John Marks

Then we had the previous reforms, Keith Joseph's. We begged him to have a pilot and he said he could not, because this had to come in on the same day as the reform of local government, and it did. Lastly, some of you may remember RAWP, the Resource Allocation Work Party.[136] They tried several pilots of that, but the only one that worked was in Winchester, where the chief surgeon was the head of the BMA's consultants group.

Graham Winyard

Can I make a point on pilots? I always thought they were a prevarication and I still do, because of the simple reason of what would happen to the rest of the NHS. We heard at the beginning that it was in crisis and getting worse after a poor settlement. Something had to be done and you came up with one solution, which is this internal market, which may or may not be right, but there was no other game in town. You could not have marked time for a few years.

Nicholas Timmins

That is a really important point. The internal market was the only new idea in town. There was nothing else.

Image 22: Kenneth Clarke

Kenneth Clarke

We had not been able to work out an alternative. That is true. The one that had most effect on my colleagues was the by-election we lost and in which Labour gained, which was entirely fought on the NHS reforms before they were implemented. Everybody was told that they would have to pay a fee to go and see their GP. The other big campaign was that pensioners were told that the GPs would strike them off their lists, because they could not afford to have pensioners under this new capitalist market system. One time, I was threatened to be sued for defamation when Robert Maxwell – who had 150-odd writs outstanding when he died for people he had tried to shut up – rang me up.[137] I had defamed his award-winning journalist by suggesting that her story that pensioners were about to be struck off GPs' lists because the system would not be able to afford them was somehow political invention.

[136] The Resource Allocation Working Party (RAWP) was appointed 1975 to develop a new formula for distributing health resources at regional level.

[137] Robert Maxwell (1923-1991) was a publisher and Chairman of Mirror Group Newspapers Ltd. (1984-1991).

This was defamation and he was about to sue me, unless I gave him an unreserved apology in writing and withdrew this attack on his newspaper's story. The campaigning was quite bitter and not always accurate and what the general public was being told, by way of reform, was not always frightfully accurate.

John James

I want to make two comments. One is that I wholeheartedly agree that pilots would not have been a sensible approach at all. You simply could not isolate anywhere other than perhaps the Isle of Man or the Scilly Isles from the whole system.

Professor Sally Sheard

You could not isolate the Isle of Man, because their patients came to Liverpool for surgery.

John James

Exactly, so you cannot isolate. Secondly, I have been hearing more negative things about the development of the purchasing than I feel comfortable with, as somebody who spent ten years doing it. When I took over as a DGM, basically there was a hospital and a community unit. Each had a unit general manager. There was a district nurse, who insisted on overseeing their nurses. There were two levels of command doing one job. Separating that out was the first thing that I attached importance to, then I could actually develop something called the purchasing side. You could have a real role for public health. You could start looking at the patient and population characteristics. That was almost non-existent in Harrow, when I went there. It was slightly better developed when I took over in Parkside, but it grew immensely. You ought to reflect on all the work which was done by collective groups of purchasers, not just in London, which I saw at first hand, but up and down the country to change things and to work together to change them. People whose voices had never been listened to in the previous system were listened to.

Nicholas Timmins

I sometimes define the change as, for the first time, the NHS actually sitting down and thinking about what it wanted to buy, and then going out to buy it. That had not quite happened before.

Dr Jonathan Shapiro

It had been doing that before in some places.

Bob Nicholls

On the previous subject, as well as Ken [Jarrold] and I agreeing with Ken [Clarke] that, without general management, the pace would not have happened, this is more of a question. You get out of touch pretty quickly, but my reading of what has gone on is the great distrust of managers that came out of general management and then implementing something that was as unpopular and disputed as this. Despite McKinsey, the 'Grey Book' and what we now think of as nonsenses, but actually, managers were there to help the nursing and medical staff to get the most out of the resources. Therefore, it was in our interest as managers to make sure that the culture was right. There was competition between hospitals, but the feeling was that we were now being pulled by the political system of the day, after Ken had gone, whatever you thought of that. I will leave that in the air.

Dr Jonathan Shapiro

Can I comment on that? I think it comes back to Griffiths, because he separated general management from the medical management of the hospitals.

Nicholas Timmins

He did not intend to; it was just what happened.

Dr Jonathan Shapiro

But it led to a perception that the manager's job was to control the money and the doctor's job was to control the clinical issues. A tension was created between the two, which we are now trying to overcome.

Bob Nicholls

The second thing, which has not been mentioned and I must get it in, because I think I invented the phrase, is that I was brought in by Duncan [Nichol] because, coming up to an election, it was beginning to be apparent – and John will know this better – that the market was beginning to have an effect on London and particularly in the flow of patients to acute hospitals. The number one research hospital in London at the time was UCL [University College London]. The fear was it would accelerate loss of patients. I came in post-Tomlinson, and we said that the trouble with *Working for Patients* from a purchaser/provider perspective is that there is no one market.[138] Where is education and training? Where is research? I suppose I should have thought of four; where is social care?

I am jumping ahead to the last part. We should test it. The things that we are talking about and were talking about is this point that we never shifted resources from acute hospitals into community primary care or mental health. Do we now? Were the benefits from establishing that culture enough?

Nicholas Timmins

Can I park that for one second, because we are going to move into the legacy part shortly? Is there anything else we need to say about implementation? There were tonnes of working papers, loads of working groups and a huge effort that went into putting flesh on to these bones. Do we need to say anything more about that than that?

Professor Sally Sheard

Could I just ask the participants if management consultant firms were considered in the way that McKinsey's had been used in 1974? If they were not, why not?

Dr Greg Parston

It is because they were in 1974. [Laughter] It is too bad Robert Maxwell is not here to talk about that.[139]

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[138] The Tomlinson Inquiry into London's Health Service, Medical Education and Research was set up in 1991 and sought to plan strategically the future health needs for London. It was chaired by Bernard Tomlinson and proposed the strengthening of primary care. See Tomlinson, B., *Report of the Inquiry into London's Health Service, Medical Education and Research*, London: HMSO.

[139] Robert Maxwell was a consultant at McKinsey & Co. (1966-1975) and Administrator at St Thomas' Hospital (1975-1980) before becoming Secretary and Chief Executive of the King's Fund (1980-1997).

Kenneth Clarke

They were used in the Keith Joseph reforms and they were generally regarded as having completely screwed up.

Bob Nicholls

It was an absolute disaster.

Dr Greg Parston

The Office for Public Management made all its money on healthcare in those days. The big companies did not have the kind of influence that they had had previously.

Kenneth Clarke

McKinsey's had this consensus management theory. Not just the public sector, but the private sector tends to run on fashionable theories for a time. Everybody that McKinsey's was advising in the 1970s was advised to go to consensus management, and it did not work. Where it broke down, it broke down big. By chance, in my days as a lawyer, one of the briefs I had had was to act as the counsel to the tribunal investigating the failure of the Solihull District Health Authority, which was a tiny little authority that had been kept going for political reasons, for lobbying. It was far too small. The managers who were meant to work in this consensus team – the administrator, the medical officer and all the rest of it – hated each other. We had a very short inquiry describing comic situations inside this little health authority, with physical barriers being put in corridors to stop people getting across. When I was Minister of State shortly afterwards, I was very heavily reinforced with the idea that this did not actually work. In some places, it certainly did not work and McKinsey's had not done a terribly high-powered job.

Dr Greg Parston

That work had been led by our Robert Maxwell, who led the King's Fund and was staunchly in favour of that. He caused great ruptures in the King's Fund, when Tom Evans began working with Roy Griffiths on the Griffiths report, because Robert was still defending consensus management.

Bob Nicholls

It might be worth doing a straw poll on the specifics. The management consultants in the previous reforms were quite in evidence. By now, I am a Regional General Manager and I am being pushed pretty hard by Duncan [Nichol] and my Chairman to use management consultants. Funnily enough, I had an OPM coach, but it was not McKinsey and it was not Pricewaterhouse. I would be interested if fellow colleagues used management consultants. I do not think we did, except when we began purchasing. When purchasing was not delivering as much as we hoped and not standing up to the big battalions, the management consultants came back in. I can think of several places where that happened.

Nicholas Timmins

By then, you are talking of the 1990s-2000s.

David Lawrence

David Lawrence from the London School of Hygiene and Tropical Medicine. I have a quick question. From the 1970s until now, we public health people received training in how to manage healthcare.

How much might training have made a difference? We have not heard about proper and appropriate training at all.

Image 23: David Lawrence.

Dr John Marks

There is one thing about administration and management. At the time of the first reforms, I was Chairman of Hertfordshire Executive Council, which was responsible for staffing Stevenage. The chap who advised us was our administrator. I asked some McKinsey chaps what the difference is between administration and management. It is easy. The trains in India run on a timetable that has been there since the 1800s. That is administration. Change one time and that is management.

Nicholas Timmins

We are heading towards the last section. We have started to touch on this, but what has the legacy been? My guess is that it has changed over time, in the sense that it had an initial impact, did one set of things and now we are all a bit disillusioned with commissioning.[140]

Ken Jarrold

I will do a little bit of history here and share it with you. If your perception is different, I would be keen to hear about it. The point was made a few days ago about Ian Dalton as the Chief Executive of NHS Improvement, which is the body that now runs the whole of the provider side of the English NHS.[141] [142] I have nothing against Ian. He is a very able guy and was actually the last trust chief executive in whose appointment I participated, as a Strategic Health Authority Chief Executive. But I am pretty sure that none of the great figures from the NHS provider world even applied for the job. Mike Deegan of Manchester, Andrew Cash of Sheffield, Julian Hartley of Leeds, David Dalton of Salford and these fantastically able people did not apply for that. Why is that? Running their trusts is perceived by them to be more significant and important than being in charge of the whole provider side of the NHS.

If we just look at that historically, the 1970s reforms were a complete disaster and we knew it very quickly, because they sucked the whole life out of the management of hospitals. I wrote a paper in 1976, as part of the Institute's evidence for the Royal Commission, which argued the case. I am not overestimating its importance, because many other people did too. The Royal Commission responded and, in 1982, we got unit general managers, then Ken gave us trusts and we had foundation trusts

[140] Strachan Heppell later added on the legacy: ''Working for Patients' seemed radical at the time in its "aim to extend patient choice, to delegate responsibility to where the services are provided and to secure the best value for money", as the Prime Minister put it in the foreword to the White Paper. It seemed particularly so in introducing the purchaser/provider split. On the other hand, it can be argued that the organisation of the NHS had changed less over the years than other post-war welfare reforms like social security and education, so that the White Paper seemed more dramatic than it was actually was.'

[141] Ian Dalton was Chief Executive of the North Tees and Hartlepool NHS Trust (2005-2007 and of the North Eastern Strategic Health Authority (2007-2011).

[142] NHS Improvement was created in 2016 and is responsible for overseeing foundation trusts, NHS trusts and other NHS providers. It brings together other bodies such as Monitor and Patient Safety.

later. If you look at the world of the NHS today, the chief executive of a foundation trust is the top job to which people aspire.

On the purchasing side, something completely different has happened. Of course, there were people like John, and I hope I was one of the others, who really tried to make purchasing work at a DHA level, but it was very difficult to do. The crucial moment for me on purchasing was when Labour came in, in 1997. That was the crucial moment. They made an ideological error in abolishing fundholding, instead of looking for a way to make it work. That was because Tony Blair was so besotted with the private sector that he had to throw a bone to the left wing of the Labour Party. The bone that he threw, with Frank Dobson's encouragement, was fundholding. What should have happened was an examination to see how fundholding could be developed fairly for the whole system.

For me, the most effective purchasing in the whole history was when primary care groups were established and worked carefully with health authorities. That really worked, but the whole purchasing thing has not worked and this latest incarnation of CCGs is a nightmare.[143] Purchasing, apart from some honourable exceptions, has not worked anywhere though. That crucial moment was 1996 and not doing something sensible then.

Nicholas Timmins

What I regretted when they scrapped fundholding was that they also scrapped a very small number of total purchasing pilots, which were basically clinical commissioning groups.[144] They were pilots. If they had let them run for five years, we would have learned a lot and may not have done what we did this time round, but they were all scrapped.

Image 24: Nick Bosanquet.

Professor Nick Bosanquet

The most positive development in the last couple of years has been the return of initiative by local GPs and groups. That is not just in Cambridge, but in York, the North West and the North East. They are moving back towards the primary care home model, which is very similar to what the fundholders were trying to do, in terms of integrated teams and more services available outside the hospital. The issues that were raised there are returning again. All credit to NHS England, which is driving forward that out-of-hospital initiative.[145] The problem is the huge

[143] Clinical Commissioning Groups (CCGs) are clinically-led NHS statutory bodies responsible for planning and commissioning health care in their local areas. They were created by the Health and Social Care Act 2012 to replace primary care trusts (PCTs). There are now over two hundred CCGs in England.

[144] In 1994 there were 52 total purchasing pilots in localities where GPs were able to purchase all services for their patients. These pilots ran until 1998.

[145] NHS England is an executive non-departmental public body, or 'quango', in the Department of Health created in 2013 and is responsible for the operational aspects of the NHS including budgets, planning and delivery of services.

monopoly in the specialist care sector. On the day after Ken's paper, I said to the *HSJ* [Health Service Journal], 'Our big problem is the huge secondary care machine. Who is going to pay for it?'. That is still there.

Dr Jonathan Shapiro

I am putting on my academic hat to make a number of observations about what I think has happened. The first is that the concept of the separation between the procurement of services and their provision has become embedded. That is really important and I do not think we can lose it. Quite how we enact it is a different question. A more negative interpretation of the initial reforms, is using a slightly old Freudian metaphor of the id, super-ego and the ego, with trusts being encouraged to be the id, the child. They were to be self-centred and want their own power and success. [Laughter] The commissioners were supposed to be the super-ego to have the conscience and the responsibility for the health of their population. The idea was that a balance of the two might lead to a more balanced personality, the ego. Frankly that has not worked, because the trusts are, by and large, very self-serving and have been encouraged to be. The commissioners cannot get a grip, because, in my view, you need some real contestability if you are going to shift stuff around and really make a difference.

The New Labour government overcame a real problem, which was a 52-48 per cent problem, as we have heard fairly recently. The people who were not in fundholding hated it, and the people who were involved loved it. The introduction of PCGs led to a relatively golden time, when the GPs felt they had some influence, without having to be sullied by the money. Then they were hurried into PCTs, which took away their choice and emphasised the money.[146] That was particularly tied with resources becoming tighter, so the GPs came in thinking they were going to be an influence just at the time when money was taken away from them. So we ended up with a pile of people who felt relatively disenfranchised. CCG governance is not very good. GPs are still very parochial and do not think very corporately, although there may be some noble exceptions. Now we are back into emergent policy with the STPs trying to recreate some sort of regional health authority and hoping that that will work because it is emergent. Actually, it has no sense of direction at all.

Dr Greg Parston

What the Rubber Windmill surfaced was that, while you could split clinicians from providers, if you did not do it in a unified, uniform way, you would have competition, not just among the providers, but among the purchasers. Later, when Labour came in, Alasdair [Liddell] was Director of Planning and I continued to work with him. We ran another simulation, called Protocol, which resulted in the design of PCGs simply to unify that purchasing strength in one place. Why is that important? I do not know that the purchaser/provider split is something that will endure. Interestingly, while the split was being devised, many of us who worked on both sides of the Atlantic would go and see integrated care systems [in the US]. They said, 'You guys are pulling it apart while we're putting it together. We're putting purchasing and provision for the whole population together.' If you take a look at the really good integrated care units, like Intermountain, Kaiser Permanente and Harvard Community Health Plan, you can see real change. You are getting the money out of hospitals and spending it on public health.

[146] Primary care trusts (PCTs) were NHS statutory bodies in charge of planning and commissioning health care at the local level. They were created in 2001 and numbered 152 in England.

Nicholas Timmins

Right now, it is slowly dying on its feet. Simon Stevens said the first accountable care systems will effectively put an end to the purchaser/provider split.[147]

Dr Greg Parston

They will do.

Nicholas Timmins

Can I put out a proposition for discussion? Money is now incredibly tight. You have a cash-limited budget, so your competition will involve moving tiny bits around tiny places, because you cannot do anything big. When you have growth money, you can, for a bit. It is sort of shrinking back, because the money is making it impossible to operate and we have lost faith in it. People keep saying it has not really worked. STPs may or may not be becoming health authorities, but we are going back to a more integrated approach. The question then arises: how do we hold the bloody things to account? Part of the purchaser/provider split was about holding people to account.

Kenneth Clarke

The height of the competition thing was midway through the Labour Government. Alan Milburn was at least as keen on my approach as I am.[148] He coincided with PCTs, and he was able to go further and faster than I could get away with politically. We have not mentioned things like diversity of provider, which is one of the things you look for if you are attracting purchasers. You get into deeper politics once you start outsourcing to have private sector providers. We had that in our first reforms, but we did nothing to push it. Alan went charging ahead, and I always joke with him that he got away with things that I could not. It has slightly run out of steam, but you have to be careful, because we all belong to this era and we all worked on introducing it. It is our baby and every health care system should be run without change from now on, which is a bit like Nye Bevan or McKinsey's.

The big problem facing the service now, apart from resources, is the rapidly changing nature of demand with the ageing population. There is the usual resistance to change inside the organisation, when it has to meet wholly different market pressures. Second is the need to integrate. I am supportive of Simon Stevens. It is the big idea right now to actually stop everybody living in their own little bungalow. That is a slight exaggeration; it is not like that everywhere. Among the hospital, GP, community care, local authorities and social services, you have to devise a system to bring them together based on individual patient needs, and then actually deliver. That is an enormous problem. I can see that the purchaser/provider split is being pushed aside, because it does not fit that very easily at all.

Professor Nick Black

Nick Black, London School of Hygiene [and Tropical Medicine]. Much of the discussion has been about disputes and about how best to institute the market. I shared much of the enthusiasm for it, after initial scepticism. It seems to me it is a wonderful occasion today to look back on it. What I want to put forward, and hear people's reaction to, is that it was fanciful. It was very similar to Nye Bevan; once we have cleared the prevalent backlog [of demand for NHS services], then we will be on a plateau. We all look back and say, 'How could he have been so naïve?' David Lawrence mentioned training, and we are one of the training institutes for this. The task of purchasing is just

[147] Simon Stevens is Chief Executive of NHS England (2014-).

[148] Alan Milburn was Minister for Health (1997-1998) and Secretary of State for Health (1999-2003).

Image 25: Nick Black

too difficult. We have no routine information on costs in the NHS. We have things called reference costs, but they are prices plucked out of the air. We do not actually know, in any two hospitals within a mile of here, how much it costs to produce a hip replacement. We know that there is poor productivity in the health service. We could do it [run an internal market], but I suspect we would end up spending 20-25 per cent of healthcare funds on collecting data at a level that enables intelligent, informed purchasing decisions, which is probably not a good way to spend the money. With the Five-Year Forward View is encompassed within that. We are moving away from an explicit separation of purchasing and commissioning. The integration does not need it, in a way. It needs awareness of costs and cost utility, but it does not need sophisticated data. We got it wrong, and I would share that. After initial hesitation, I was as enthusiastic as Ken was.

Jeremy Hurst

Can I just chuck in an economist's point? There is quite a lot of evidence, of a reasonably respectable kind, done by econometricians, comparing the effectiveness and efficiency of the arrangements in England to the arrangements in our Celtic neighbours Wales, Scotland and Northern Ireland. Apart from the early days with the first version of the internal market, when Carol Propper cast some doubt on whether the arrangements were driving up or down quality – in the days when you could compete on price – now with fixed prices you can only compete on quality.[149] Since then, I have not seen any econometric results that do not suggest that England does better than Scotland or Northern Ireland, which have no internal market, and so on.

There was a radio programme that I caught last week about Northern Ireland, and they are in a desperate state. Now, there are other factors, because they have no government at the moment, but they are nowhere near meeting the waiting time targets. There are huge waiting lists. Lots of people are waiting over a year for routine operations. Some are waiting over five years for routine operations.

Nicholas Timmins

Is there any evidence, apart from the fact that England has the purchaser/provider split, that in itself it is responsible for that? I am not aware of that.

Jeremy Hurst

I would cite pricing and costing, which has just been disparaged, but I would say is an enormously important introduction, so that there is now a schedule of 1,000 prices for procedures. Money follows the patient. There is no longer an efficiency trap whereby, if you did a good job, you were not rewarded for it. Now you get rewarded if you do a good job. There are now reforming possibilities through purchasing. It may not be the success we wished for, but at least those purchasers have a lot of clout.

[149] Carol Propper is a British health economist. See Propper, C.; Burgess, S. and Gossage, D. (2003), *Competition and Quality: Evidence from the NHS Internal Market 1991-1999*, CMPO Working Paper Series No. 03/077.

Nicholas Timmins

I do not want to dominate the conversation, but it may be that comes because you have costing data and the ability for the money to follow the patient. You can have that without the purchaser/provider split.

Image 26: Jeremy Hurst.

Jeremy Hurst

You are absolutely right. In the final analysis, I do not know if anybody has scientific evidence that says that the internal market worked or worked better than reasonable comparators, leaving aside other countries. You are right that there are multi-causal factors going on. It may be that it is simply the increase of information that is doing a good job.

Dr Graham Winyard

I would argue that the benefits that the reforms had have largely come from the support programmes, many of which we have not talked about, which were introduced alongside and as part of them. To me, the original question asked at the time about the internal market was how will this help? What is the case, in most parts of the country, where you have a purchaser and it is the local hospital or the local mental health service? There is not a lot of overlap. I think it has developed a huge bureaucracy between the two, with lots of managers interacting with each other. My daughter is one, so I have inside glimpses of this. [Laughter] The machine has lost touch with patient care.

Dr John Marks

I suspect I am the only person in this room who worked in healthcare before there was an NHS. I was a third-year medical student when Bevan's ideas were promoted and I was almost the only student in Edinburgh who was in favour of them. At St Mary's, they burned effigies of him. I believed in it from day one. I qualified as a doctor on 5 July 1948, which is the day the NHS started. I used to joke that, if I live long enough, I might see the end of it. Sadly, I do not find that a joke anymore.

[Interruption by Mr Ken Clarke]

Kenneth Clarke

Bevan was described as a 'medical führer' by the BMA.[150] There is no other easy explanation for the comparative improvement of the English, compared to the Scots, Welsh and Northern Irish. The Scots, Welsh and Northern Irish made a quite deliberate devolved decision to resist reform. They

[150] During the formulation of the NHS, a former Chairman of the BMA is said to have examined the Bill and recognised the first step 'to national socialism as practiced in Germany' and that the medical service would be put under the dictatorship of a 'medical führer'. See BBC News, 'Making Britain Better', 1 July 1998: http://news.bbc.co.uk/1/hi/events/nhs_at_50/special_report/119803.stm

believed that, as far as possible, they are sticking to the old pattern of the BMA. There may be features of the reform, not just purchaser/provider, but all the improved management information.

These meetings about the health service are always gloomy, in some ways. This one has not been; it has been great fun. People always think that the health service, at the moment, is on the point of collapse and that it has never had a crisis like it. I always cheerily say to my successor Secretary of State that, at the very least, you will find you are running up an escalator that is going downwards. If anything is going to change, the escalator will go faster in the future. We always believe we are in crisis.

As we are all people who were very involved in the health service 25-30 years ago, take a step backwards. For the first time in my life, I have recently been a patient. It is unbelievably better than it was 30 years ago. The NHS, which all of us here support, has been able to change so much as to respond to the vast advancements in clinical care, with the huge increase in patient expectations and all the pressures upon it, so it cannot have been that bad. For all your defence of the single market against any further changes and the tradition of the health service of a resistance to change, I remain optimistic. If the reforms are carried out sensibly and we change to a quite different pattern of demand, we can continue to improve it.

I defend the idea of a publicly funded service, free at the point of delivery, based on clinical need. Right-wing people and commercial lobbyists will still tell you that it is fundamentally flawed, cannot work and quite dreadful. Sooner or later, reality is going to dawn and you will have to privatise it, which we have always been accused of, but no one has ever tried to do. I do not believe that. I think the NHS is an extremely good example of a system that, despite all of its innate conservatism – with a small 'c' – and resistance to change, it has been changed quite remarkably. Frankly, the old deferential patients did not complain about the dreadful level of care we used to give them. Everything has been transformed about the service, not least mainly being in hospitals full of people convalescing after minor operations, being given tea and biscuits by the nurses. The pressure at which it works now is fantastic, with everybody in hospital beds actually ill or at least recovering very rapidly from something they have just had done to them. The demands upon it are vast compared to the ones we met 20-30 years ago.

Dr John Marks

May I continue after that interruption?

Nicholas Timmins

You can in a second.

Sir Terence English

I want to make a very quick referral to Nick Black's point about the problem of purchasing and not having the information that you need. I was at the Mayo Clinic a couple of years ago and went around with the CEO [Chief Executive Officer] there.[151] I asked him if the Mayo was having problems with the HMOs, which were trying to drive down costs in all the hospitals in America. He said, 'No, we don't negotiate with them. We give them a price and we tell them that that comes with a badge of Mayo quality, and that is the end to it. They either accept it or they do not.' That is something to think about.

[151] The Mayo Clinic is a not-for-profit health care organisation in the USA focusing on medical research and practice.

Dr Jonathan Shapiro

Nick, I think you are taking a slightly narrow view of the purchaser/provider split and using it reductively. The point I was trying to make, which is coming out from some of this discussion, is on the separation of incentives. Providers are there to do more. That is what they want to do. How you control that, and the whole notion of commissioning, encompasses much more than setting contracts. It includes strategic commissioning and all that sort of thing. That is now embedded. We absolutely need particular mechanisms and some way of working better together. One of the benefits of the 1990 reforms was better clinical cooperation between primary and secondary care. That was one of the few tangible benefits of fundholding.

Dr Greg Parston

With the emergence of PACS [Primary and Acute Care Systems] or ACOs [Accountable Care Organisations], we are going to see radical transformation.[152] [153] Integrated care systems do not call themselves health services; they call themselves health and wellbeing companies. They are spending an increasing amount of their money on public health, closing hospitals and doing lots of things. When we look at how policy is going to be formulated around them, we should learn what more integrated, uniform and purpose-led purchasing can achieve within that context.

Dr John Marks

Look at the situation at the minute. GPs cannot find partners. Junior doctors, including my own grandson, are emigrating in droves. Consultants are retiring at 60. People are being offered one cataract operation and deaf people are being offered one hearing aid. That is the reality of life. After they have waited a year or two, kids with mental illnesses are transported umpteen-hundred miles to a hospital to take them in. If that is a successful NHS, I am Ken Clarke. [Laughter]

Nicholas Timmins

The day might yet come.

Bob Nicholls

Some of the things about the need for contestability in the market have not come out. We never had a failure regime and we still cannot close hospitals that are uneconomic or even poor-quality services. My favourite is the Horton in Banbury. We managed to close obstetrics and children, because we have a good clinician, female, who is tough and has stood up against the politicians. The clinicians are all fighting for something that is not safe. It is not good. We did not have a failure regime in the market.[154]

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[152] PACS were outlined in the NHS Five Year Forward View and aim for a single entity or group of providers to take responsibility for delivering health services for a given local population, seeking improvements in coordination, especially between health and social care. See Ham, C. et al. (2016), *Policy changes to implement the Five Year Forward View*, London: The King's Fund.

[153] ACOs, like PACS, aim for a greater integration of health services and are inspired by US organisations.

[154] Bob Nicholls later added about this example: 'Despite good financial and safety arguments, plans for withdrawing consultant led Obstetric and Paediatric services have been thwarted for over 30 years. Following yet another consultation process recently, well led by a local clinician, and the rejection of an application for judicial review, final decisions are still "under review" by Ministers. There are many such examples all suggesting that the "internal market" lacks contestability and any sort of failure regime.'

Image 27: Bob Nicholls, Nick Bosanquet and John James

Nicholas Timmins

Is that not because you cannot actually close a hospital just because it has gone bust?

Bob Nicholls

Exactly but you can have contestability. London started to have some, but we did not do anything near as much as we should.

Jeremy Hurst

You can change the managers.

Bob Nicholls

We do that all the time. We do make some changes. Another thing that has not come out, which I really worry about is Nick [Black]'s point that we need more information to do this properly. And yet, we are spending a lot more on what used to be called administration. I think it was 4 per cent or 5 per cent, maybe up to 6 per cent. I now understand we are near 14 per cent - mostly to run an imperfect market.

Jeremy Hurst

Do you believe the numbers? I have always been very suspicious of them.

Bob Nicholls

It is probably too big, but the cost/benefit is the point. Is this the best way to spend it?

Professor Nick Bosanquet

I have one final piece of good news. I was one of the founders of the British Survey of Social Attitudes. In the early 1980s, figures on satisfaction for the health service were running at about 40 per cent. In the last few years, they have been running at 60-70 per cent. That has continued, even during this period of tightened funding.

John James

I was going to disagree with Kenneth Clarke, if I may. I think Alan Milburn's reforms were a major setback. He doubled the number of organisations on the purchasing and communities side, at the same time letting a good quarter of the chief executives and directors go. We needed far more managers and smaller units – insufficiently large. The smallest PCT was 40,000 people.

Nicholas Timmins

There is a real irony that the man who made his name attacking the men in grey suits actually created more managers.

Kenneth Clarke

I also feel that Andrew Lansley is the one I tend to think was most responsible for the proliferation of organisations and management.[155] I give him credit for creating NHS England, because that was an attempt to depoliticise some of these impossible problems. Closing hospitals can only be done now if you have the right number of clinicians prepared to assert that they will take over. You can try to close the most clapped-out A&E department you have ever seen and, within five minutes, you will get a petition with 50,000 signatures on it to save this centre of clinical excellence. It gets

Image 28: (Left to right) John James, Jonathan Shapiro, Greg Parston, Kenneth Jarrold, Bob Nicholls, Nick Timmins, Strachan Heppell, Grahan Hart, Marshall Marinker and John Marks.

[155] Andrew Lansley was Secretary of State for Health (2010-2012) and oversaw the formulation of the 2012 Health and Social Care Act.

increasingly difficult to do that. NHS England was an attempt to put professional and clinical judgment in control of more of these things, and it could work in some ways.

Bob Nicholls

Congratulations to Sally and the Liverpool team for setting up this meeting. It has felt a bit like that film about ageing cowboys, coming together for the last round. [Laughter]

Nicholas Timmins

On that cheerful note, you gunslingers can go home. Can I say thank you very much indeed to you for coming.

[Applauses and End]

Image 29: Sally Sheard and Kenneth Clarke

Appendix 1: Note prepared by Professor Alain Enthoven in advance of the witness seminar based on questions by Professor Sally Sheard, 5 December 2017

Preface: these events mostly took place over 30 years ago and my memory for dates and names now is not very good. These answers are either my best recollections or they are based on my 1985 "Reflections…" Nuffield Trust Occasional Paper, or on my Rock Carling 1999 Lecture.

1. When did you first have contact with UK-based economists and government ministers? For what reason?

My career in health policy began in 1967-70 when I served on the Board of Directors of Georgetown University and on the Medical Center Committee. I learned that the government and insurance companies paid for the care of patients on the basis of cost reimbursement for hospitals and fee for service (FFS) for physician services, both cost-increasing incentives.

The Department of Community Medicine recognized that the prevailing model of open-ended uncoordinated FFS was unsustainable and they launched a study of what would be the sustainable model for the long run to which they could expose their students. They concluded that the sustainable model would be Prepaid Group Practice, and they created Georgetown University Community Health Plan. Prepaid Group Practice meant a multi-specialty group practice paid by per capita pre-payment for comprehensive care of enrolled members. I followed the study with interest, and as an economist, I particularly liked the incentives alignment (the model rewarded providers for keeping patients healthy and solving their medical problems well and promptly). I played the minor role of introducing the proposal to my fellow directors, with my positive endorsement. Subsequently, upon leaving the Department of Defense, where I had been appointed Assistant Secretary of Defense by President Lyndon Johnson, whose term and mine ended in January 1969. I joined Litton Industries and became President of their Medical Products Subsidiary, a multi-national medical technology company. I learned there that doctors and hospitals were not interested in quality-cost-effective products because the payment system did not reward economy.

Also, some doctors came to us and proposed we join them in creating an HMO. So I did a thorough study of HMOs. I concluded that HMOs were a good idea for the nation because of the incentives alignment, but a bad idea for Litton Industries because we were a short-term profit oriented company, and HMOs must be non-profit to win and keep the trust of patients.

Then, in 1973, I accepted a new professorship in Public Management at the Graduate School of Business at Stanford University. At the same time, I called on the top management of Kaiser Permanente, then and now the leading HMO, because I believed in them (and still do), told them what I had done, and proposed a consulting relationship. There, for the next 40 years, I did a variety of things for them (including negotiating an affiliation between Kaiser and Georgetown University Community Health Plan) and I watched them constantly innovating to improve quality and value for money for their enrolled members, including the smooth and successful adoption and use of electronic health records.

In 1976, Jimmy Carter ran for President with the promise he would bring us "universal, compulsory, comprehensive, health insurance". He appointed Joseph Califano to be Secretary of Health and Human Services. Califano and I had been friends and colleagues in the Johnson Administration. And I had just been elected to what is now the National Academy of Medicine. He asked me to become an Assistant Secretary in his Department and to design a plan for universal health insurance. I couldn't bear the thought of leaving Stanford and moving my family again, but I agreed to work for him as a consultant and develop a plan for universal health insurance by commuting between California and Washington. There was a great deal of interest in what I might come up with. In 1978, I presented a plan that I called "Consumer Choice Health Plan", based on what I came to call "Managed Competition" in the private sector. The Editor of the New England Journal of Medicine proposed to publish it and did so in a two-part article in 1978. This attracted a great deal of interest, and led to bi-partisan legislative proposals. Unfortunately, Jimmy Carter went in a different direction (an unsuccessful attempt to impose price controls on hospitals), but some of the ideas continue to attract interest, and they showed up in the exchanges in the Affordable Care Act.

In 1983, I returned to England to attend the 80th anniversary of the Rhodes Scholarships. There I saw Sir Edgar Williams, Warden of Rhodes House and a good friend. He told me that he was the Chairman of the Board of the Nuffield Provincial Hospitals Trust (now the Nuffield Trust). He must have read about or heard about my New England Journal articles. He told me they (the Trust) would like me to come to England, do a review of the NHS, probably hoping that I could offer a comprehensive plan of incentives reform as I had done for the USA.

So in 1984 I came back to London, I think but am not sure for four or five weeks. Gordon McLaughlin said they would like me "to meet everyone, talk to everyone, and at the end of my visit, give a talk to the Directors, and if they liked it, they would ask me to write it up and they would publish it as an occasional paper," which did happen.

We came back in the Spring of 1985 to Oxford to write it up and discuss with as many people as I could find and who were interested. We were guests of St. Catherine's College whose warden was Sir Patrick Nairne. (We had known each other in our previous incarnations as Defense officials.)

2. Who made the invitation to you?

I think Sir Edgar Williams had the idea and influenced Gordon McLachlan to extend and manage the invitation.

3. What was the nature of your contract/visiting status? Did they set detailed parameters for what they wished you to focus on?

No contract, no detailed outline. It was just as I described above.

4. How long did you spend in the UK during your Nuffield Trust visit (and when did you return for subsequent visits?)

About four or five weeks on the first visit, and about eight weeks on the second visit. I gave some seminars at Oxford, and I think it was on this second visit that we went up to York to meet Alan Maynard and the other York health economists. I did a seminar at York.

5. What was the reaction from the Nuffield Trust to your report?

Evidently the Trustees liked my talk and invited me back. I am not sure but I think Gordon McLachlan was a bit uncomfortable with my talk about markets in the NHS. I do not remember that well.

6. When did you next have contact with UK economists/Department of Health Officials/government ministers? In what format?

At that time, no officials or ministers. As to economists, see question 4.

7. Did you have direct contact with Margaret Thatcher?

Almost none. In the summer of 1990 she and I were at a meeting at the Aspen Institute. She gave a most memorable talk on "What is Democracy?" I had heard that my report had gotten her attention. She recognized my name. In the receiving line and shaking hands, I tried to say something about the need for pilot projects and she replied firmly that they were going to go right ahead. This was a very brief exchange.

8. Were you consulted when the government was developing its 1991 plans?

No, not at all. If I had been, I would have repeated my recommendation for at least a few pilot experiments.

9. My view on pilot studies?

I believed strongly in pilot studies because neither I nor anybody else knew how to construct a market in the NHS. In my 1985 report, I called for pilot studies several times and recounted valuable American experience with pilot studies and proposed a list of pilot studies for the UK. I never thought I had a well worked out plan, nor did anybody else have one. I just offered tentative ideas for further study.

10. What is your assessment of the success/effectiveness of the 1991 internal market reforms?

I came back in 1998-9 to answer that question and to give the Rock Carling Lecture. Please see Chapter 6, of the Rock Carling lecture, Overall Assessment. I said: "The Conservative government did not come close to creating and unleashing market forces to the extent that might have been possible."

Let me refer you to pages 58-60. I don't have the time to re-type those sentences. But my views are summarized in the topic sentences of Chapter 6. I did think that G.P. Fund-holders were a great idea. But that was Alan Maynard's idea, not mine. I was sorry I didn't think of it. I did see some very good examples where many fund-holders got together, pooled resources, hired nurses to help manage patients with chronic conditions. I was glad to see that the Blair government, after vowing to abolish fund-holders instead made all GPs fund-holders in Primary Care Trusts.

11. What could/should have been done differently?

Do what I thought I was recommending, that is several well-designed pilot studies with analysis of the results and application of the lessons learned to the design of the Internal Market.

12. Was there an appropriate blend of expertise in the 1991 reforms?

I don't know but I doubt it.

13. Were economists adequately embedded in the planning process?

I do not know. I was not. Ask the British economists. I doubt they were embedded in the planning process at all.

14. Was there a role for management consultancy firms such as McKinsey & Co. who were involved in the 1974 reorganizations?

I don't know. I have met some very bright McKinsey people who might have offered good ideas.

Let me conclude by saying I did not see myself as putting forward a well thought out plan. I thought I was sending a thank-you letter for very pleasant visit to the UK with a few tentative suggestions. As McLachlan pointed out in the introduction to the 1985 paper, I did have some background in British institutions and culture. I spent two years in Oxford as a Rhodes Scholar, but no contact with the NHS. My father was English and I had a large English family including a doctor who has kept me up to date on what is happening in British medicine. Experience with the NHS was a part of some conversations.