Restoring the NHS: abolishing marketised commissioning is necessary but not sufficient

Your recent front-page headline 'Ministers to seize control of the NHS' (6/2/21) and the subsequent editorial reported, mostly with positive comment, on the leaked government White Paper proposing major NHS reforms. Central to the proposals is the abolition of the purchaser–provider split, with its complex and cumbersomely contentious marketised commissioning.

For thirty years successive governments cleaved to the mistaken notion that best healthcare was best assured by 'market discipline'; this was zealously amplified by Lansley's 2012 Health and Social Care Act. Yet for these three decades the government has had mounting feedback from practitioners and patients about the speciousness of these reforms – rather than getting 'market discipline' we were getting, instead, not just market mendacity and expedience, but then the kind of anomie, human heedlessness and mistrust that can come from the worst kind of corporate commercialism.

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

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

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

The erstwhile vocationally motivated smaller GP surgery, and the hospital consultant-led firm, could more easily provide such 'integrated care' because it was a natural extension of their personally informed and performed practice.

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

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