NHS0042

Written evidence by Dr Michael Lambert

Profile and Reason for Submission

I am an academic historical sociologist of the welfare state and social policy in twentieth century Britain specialising in governance and policy processes. My approach has been to develop multi-layered complex small-scale local or regional case studies to understand these dynamics.

In 2017 I completed my doctoral thesis on decision-making in local authority social services (primarily children and families) in the North West of England from 1943 to 1974, funded by the Economic and Social Research Council (ESRC) at Lancaster University History Department.[1] This research has also informed several subsequent publications.[2] I was subsequently commissioned to undertake preliminary research for The Prince's Trust concerning the child migration policies and practice of the Fairbridge Society as part of the Scottish Child Abuse Inquiry.[3]

From 2017 to 2019 I was a Research Associate on the Governance of Health project at the University of Liverpool funded by the Wellcome Trust. Here, with colleagues, I was involved in producing several elite witness seminars on different policy issues within the NHS over time.[4] My strand of the project examined decision-making in the National Health Service (NHS) in Liverpool and the city region from 1948 to the present, and as part of this I have a forthcoming book with Liverpool University Press examining governance and policy issues in the NHS on Merseyside from 1978 to 1996.[5]

Since 2019 I have been a Postdoctoral Fellow in Social Inequalities at Lancaster University, with a research focus on the centrality of care to global understandings of, and developments of alternatives to, social and economic inequalities. Here, I have consolidated my existing research interests through a series of applied case studies on 'learning' from history in health and social care services for both practitioner,[6] and general audiences.[7]

Across each of these appointments I have regularly submitted evidence to a range of Parliamentary Committees and external inquiries relating to 'learning' from history in the organisation and delivery of health and social care services. These include the Public Accounts Committee,[8] Health and Social Care Select Committee,[9] the Housing, Communities and Local Government Select Committee,[10] and the Joint Committee on Human Rights.[11]

This submission builds on this experience of using robust archival and oral history research to 'learn' from history in relation to waiting times, lists and policies in the NHS.

Learning from Histories of Waiting

1. **History does not repeat but it rhymes**. In 1987 John Yates published *Why are we waiting* based on his work at the University of Birmingham Inter-Authority Comparisons and Consultancy (IACC). He stated that there were five 'dreary old answers' rehearsed by those unable – or unwilling – to do anything about waiting lists in the NHS.[12] They were:

a. Statistics are too inaccurate to use.

b. Waiting-lists will always exist.

c. More resources are required.

d. The NHS is inefficient.

e. There is one service for the rich and another for the poor.

Although impossible to predict the future, it is incredibly likely that each of these will be, again, rehearsed during the course of the work of the Public Accounts Committee hearing. If these 'dreary old answers' were of limited value in tackling waiting in the NHS more than thirty years ago, they are arguably even less valuable today. **History does not offer clear cut 'lessons', but 'learning' opportunities.**

2. **A focus exclusively on the concerns of the present overlooks the longevity of waiting list experiences and policies in the NHS**. Waiting lists have always existed but his does not imply they always will. Writing in 1993, Stephen Frankel commented that:

> The nature and content of waiting for treatment in the National Health Service has remained remarkably stable since the inception of the service, and yet much writing about waiting lists implies that the phenomenon is an aberration which demands ready solutions.[13]

There is tendency by political figures to claim that the waiting list problem they are managing is new, unprecedented or exceptional. This myopia has been worsened by the erosion of institutional memory within the bureaucratic structures of both the Department of Health and Social Care (DHSC) and NHS England. The result is action before knowledge which grasps towards previous failed solutions.[14] Waiting list crises are not new and should not be treated as such.

3. **The growing politicisation of waiting lists and times will inevitably lead to interference to improve their public image regardless of whether change has been achieved**. As Sally Sheard notes, 'reliability – or rather malleability – of statistics for waiting lists and times appears to have been responsive to political pressures'.[15] Whether command-and-control, markets, or targets, public waiting list politicisation produces the same end result following interference: damage.[16] If anything, this type of national political interference causes further anxiety, a shift in essential resources from frontline care into managerial protection by NHS organisations.[17] Politicisation brings benefits in terms of increased attention, scrutiny and accountability, but it also opens the door to micromanagement, interference and vacillation.

4. **Waiting is not a universal experience but varies by place, time, patients, professionals and precedent**. As Nick Timmins suggests, 'the NHS is not one single organisation but many hundreds of organisations…. Each has its own history, culture and local circumstances.[18] These histories inform the present and any single blunt policy instrument will fail to capture the diversity of circumstances to be found across health and social care services. Sally Sheard has convincingly argued in her reflections on health policy and waiting times that:

> Addressing both national and local waiting list and waiting time issues has been a chronic source of tension in the UK NHS. Repeated local studies demonstrated that it was difficult to attribute blame to single factors, or to clear disparities between supply and demand.[19]

The Liverpool experience provides a case in point, with Mersey Regional Health Authority (RHA) ascending from being the very worst to best performing region from 1983 to 1994; this, despite the vagaries of the Waiting List Fund (WLF) launched in 1986 which sought to tackle structurally mounting backlogs through a single intervention.[20] Although partially attributable to such a high baseline figure,[21] there was undoubtedly a targeted regional strategy which was sensitive to a diversity of experiences across different District Health Authorities (DHAs) which reflected an understanding of the interconnection between supply and demand.[22] Although given the national political commitment to reducing waiting times, this was not without its own manipulation.[23] Crucially, local and regional waiting lists exist within their own NHS systems rooted in time, space and place.[24] Waiting is not a universal but particular process which requires a nuanced response.

5. **Waiting should not be treated in isolation from the rest of the NHS health system**. Historical understanding of waiting lists and their management shows that policies and decisions cannot be divorced from the range of reforms, changes, and activities taking place across the NHS. The WLF of the 1980s was developed during the transition from the 'old' command-and-control NHS to the 'new' marketised one and reflected a changing approach to incentivising behaviours at managerial and clinical levels.[25] The 'targets and terror' of the payment-by-results mechanism introduced during the 2000s which produced a 'historically significant decline in waiting times for NHS services' according to Adrian Kay,[26] occurred at a time of record investment across the entire NHS system.[27] In the current context of major

structural reform with the creation of Integrated Care Systems (ICSs), a review into NHS leadership by Sir Gordon Messenger, ongoing revision to long-term plans, workforce shortages, a primary care system on the verge of being overwhelmed and the appointment of a new Chief Executive during a global pandemic, never mind the changing practice of medical care itself, waiting lists need to be treated as part of this large systemic whole. As a consequence, a discrete and distinct focus on waiting lists can be counterproductive and reaffirms a mistaken view that anomalous backlogs can be swiftly and forever conquered through a single intervention. History shows that this is not the case.

6. **Increased use of private facilities in the short-term to reduce demand will erode public capacity in the NHS in the long term**. Rising waiting lists is good business for the private health sector in Britain. On the one hand, since the WLF in the 1980s, the use of private sector facilities to treat NHS patients has become a widespread and common mechanism to meet waiting list targets or drive incentives on times and treatment.[28] On the other hand, rising waiting lists invariably lead to patients able to afford treatment using their resources to jump the queue, entrenching existing waiting lists and offering a considerable financial and professional distraction to consultants employed across the sectors.[29] This also cements inequalities of access, care and treatment for those unable to pay who typically experience greater needs in relation to the NHS.[30] In short, growing private capacity to meet NHS backlogs or waiting list queue-jumpers confirms Julian Tudor-Hart's famous inverse care law.[31] Long-term structural dependency to reduce waiting lists with the private sector in turn erodes both the quality and quantity of available care in the public sector. As the Covid-19 pandemic has demonstrated, when this is in demand it cannot readily be provided or replaced to meet exceptional circumstances. Equally, the private sector is not up to the job of providing additional capacity as it largely relies on staff who work across both sectors[32] and who, in a time of crisis, commit to working for the NHS. People are the NHS, not bricks and mortar, and cannot readily be mobilised if short-term gains are bought at the expense of long-term losses.

7. **Overcoming waiting in the NHS cannot be dealt by intensifying activity or demanding increased out- or throughput, but by reforming the entire dynamics of the health system**. These take time, require integrated, collaboration and cooperation which are built over time and recognise the interconnected dynamics of planning, organising and delivering complex health services. These relationships are undermined by a short-term political focus on results based on a simple diagnosis and solution.

[1] Michael Lambert, '"Problem families" and the post-war welfare state in the North West of England, c. 1943-74', unpublished PhD thesis, Lancaster University, 2017. Available: https://eprints.lancs.ac.uk/id/eprint/86404/1/2017LambertPhD.pdf.

[2] Michael Lambert, 'In pursuit of the "welfare trait": recycling deprivation and reproducing depravation in historical context', *People, Place and Policy*, 10:3 (2016), 225-238; id., 'État-providence et gestion de la pauvreté en Grand-Bretagne moderne', *Revue Quart Monde*, 246 (2018), 32-38; id., 'Between "families in trouble" and "children at risk": historicising 'troubled' family policy in England since 1945', *Children and Society*, 33:1 (2019), 82-91; Michael Lambert and Stephen Crossley, '"Getting with the (troubled families) programme": a review', *Social Policy and Society*, 16:1 (2017), 87-97.

[3] Michael Lambert, *Preliminary report concerning historical child migration policies, procedures and practices of the Fairbridge Society in relation to the Scottish Child Abuse Inquiry* (London: The Prince's Trust, 2019).

[4] Eleanor Mackillop, Sally Sheard and Michael Lambert (eds.) *The development of health economics and the role of the University of York: a witness seminar transcript*. Liverpool: University of Liverpool Department of Public Health and Policy, 2018; Eleanor Mackillop, Sally Sheard, Philip Begley and Michael Lambert (eds.) *The introduction of the National Health Service (NHS) internal market: a witness seminar transcript*. Liverpool: University of Liverpool Department of Public Health and Policy, 2018; Michael Lambert, Sally Sheard and Philip Begley (eds.) *Mersey Regional Health Authority, 1974-1994: a witness seminar transcript*. Liverpool: University of Liverpool Department of Public Health and Policy, 2020.

[5] Michael Lambert, *Managing decline: governing the National Health Service in Liverpool, 1978-1996*. Liverpool: Liverpool University Press, forthcoming 2023.

[6] Michael Lambert, 'Lancashire and South Cumbria New Hospitals Programme: once in a generation or generation gap?', *Morecambe Bay Medical Journal*, 8:10 (2021), 284-287; id., Fortunate men or penny collectivists? General practice in Lancashire and Westmorland during the "classic" NHS', *Morecambe Bay Medical Journal*, 8:11(2021), 301-305; id., 'Medical education, workforce inequalities, and hierarchical regionalism: Lancaster University and the unrealised Medical School, 1964-68', *Morecambe Bay Medical Journal*, forthcoming.

[7] Michael Lambert, 'The virtues of decentralisation for health services in crisis', *History & Policy*, Policy Paper, 12 February 2021. Available: http://www.historyandpolicy.org/policy-papers/papers/the-virtues-of-decentralisation-for-health-services-in-crisis, id., 'The vices of patronage for health services under reform', History & Policy, Policy paper, 21 July 2021. Available from: https://www.historyandpolicy.org/policy-papers/papers/the-vices-of-patronage-for-health-services-under-reform

[8] Michael Lambert, 'Written evidence submitted to the Public Accounts Committee Inquiry into the Troubled Families Programme', October 2016. Available from: https://data.parliament.uk/WrittenEvidence/CommitteeEvidence.svc/EvidenceDocument/Public%20Accounts/Troubled%20Families/written/39004.pdf.

[9] Michael Lambert, 'Written evidence submitted to the Health and Social Care Committee Inquiry into Delivering Core NHS and Care Services during the Pandemic and Beyond', May 2020. Available from: https://committees.parliament.uk/writtenevidence/2721/pdf/.

[10] Michael Lambert, 'Written evidence submitted to the Housing, Communities and Local Government Committee of Inquiry into the Funding and Provision of Local Authorities' Children's Services', March 2019. Available from: https://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/housing-communities-and-local-government-committee/local-authorities-childrens-services/written/93900.pdf.

[11] Michael Lambert, 'Written evidence submitted to the Joint Parliamentary Committee on Human Rights Inquiry into the Right to Family Life: Adopted Children of Unmarried Women, 1949-1976', October 2021. Currently in progress.

[12] John Yates, *Why are we waiting: an analysis of hospital waiting-lists* (Oxford: Oxford University Press, 1987), 5-6.

[13] Stephen Frankel, 'The origins of waiting lists', in Stephen Frankel and Robert West (eds.) *Rationing and rationality in the National Health Service: the persistence of waiting lists* (Basingstoke: Macmillan, 1993), 2-3.

[14] Jo Maybin, *Producing health policy: knowledge and knowing in government policy work* (Basingstoke: Palgrave Macmillan, 2016).

[15] Sally Sheard, 'Space, place and (waiting) time: reflections on health policy and politics', *Health*

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[17] David A. Buchanan and John Storey, 'Don't' stop the clock: manipulating hospital waiting lists', *Journal of Health Organisation and Management*, 24:4 (2010), 343-360.

[18] Nick Timmins, *The chief executive's tale: views from the frontline of the NHS* (London: King's Fund, 2016).

[19] Sheard, 'Space, place and (waiting time)', 243.

[20] The National Archives (TNA), London: JA 536/79 Waiting Lists and Times Unit and the Economic Advisers Office, 'The Waiting List Fund 1987/8: an assessment', August 1988.

[21] TNA: BN 155/140 Mersey RHA, 'Waiting lists: presentation by the Head of Performance Review', September 1986.

[22] Ian Cumming, 'The North West approach', in *Waiting lists: is it realistic to target their elimination* (Keele: Mercia Publications, 1995), 23-33.

[23] Chris Minhill, 'True hospital waiting lists "double official figures"', *Guardian*, 2 February 1994, 2.

[24] Chris Pollitt, *Time, policy, management* (Oxford: Oxford University Press, 2008), 75-8; Lorelei Jones, 'Sedimented governance in the English National Health Service', in Mark Bevir and Justin Waring (eds.) *Decentring health policy: learning from British experiences in healthcare governance* (London: Routledge, 2018), 17-33.

[25] Carolyn H. Tuohy, Accidental logic: the dynamics of change in the health care arena in the United States, Britain and Canada (Oxford: Oxford University Press, 1999), 62-70; Juan I Baeza, *Restructuring the medical profession: the intraprofessional relations of GPs and hospital consultants* (Maidenhead: Open University Press, 2005), 13-29; Chris Ham, *Health policy in Britain. 6th edition* (Basingstoke: Palgrave Macmillan, 2009), 30-48.

[26] Adrian Kay, 'Cutting the wait – at least for a while: the NHS's assault on waiting times', in Paul t'Hart and Mallory Compton (eds.) *Great policy successes* (Oxford: Oxford University Press, 2019), 63

[27] Calum Paton, *New Labour's state of health: political economy, public policy and the NHS* (London: Routledge, 2006), 93-155; Rudolf Klein, *The new politics of the NHS*. 7th edition (London: CRC Press, 2013), 186-278.

[28] Anthony Harrison and John Appleby, 'Reducing waiting times for hospital treatment: lessons from the English NHS', *Journal of Health Services Research and Policy*, 14:3 (2009), 168-73.

[29] Joan Higgins, *The business of medicine: private health care in Britain* (London: Macmillan, 1988), 179-97; John Yates, *Private eye, heart and hip: surgical consultants, the National Health Service, and private medicine* (London: Churchill Livingstone, 1995); Caroline Richmond, 'NHS waiting lists have been a boon for private medicine in the UK', *Canadian Medical Association Journal*, 154:3 (1996), 378-81.

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[31] Julian Tudor-Hart, 'The inverse care law', *Lancet*, 297:7696 (1971), 405-12.

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