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**Institutional Hypocrisy**

**David Runciman**

* *Restoring Responsibility: Ethics in Government, Business and Healthcare* by [Dennis Thompson](https://www.lrb.co.uk/search?author=Thompson,+Dennis)  
  Cambridge, 349 pp, £16.99, November 2004, ISBN 0 521 54722 9
* *NHS plc: The Privatisation of Our Healthcare* by [Allyson Pollock](https://www.lrb.co.uk/search?author=Pollock,+Allyson)  
  Verso, 271 pp, £15.99, September 2004, ISBN 1 84467 011 2
* *Brown’s Britain* by [Robert Peston](https://www.lrb.co.uk/search?author=Peston,+Robert)  
  Short Books, 369 pp, £14.99, January 2005, ISBN 1 904095 67 4

Hypocrisy is such a ubiquitous feature of democratic politics that it can be hard to take it seriously. Indeed, taking it seriously is sometimes held to be a sign of political immaturity, or worse still, just more hypocrisy. We know that politicians can’t possibly sustain all the absurd contortions we demand of them as the price for securing our votes. In such circumstances, to insist that democratic politicians should honour all their promises, and practise what they preach, is itself absurd, and likely to breed cynicism and contempt. In an essay entitled ‘Hypocrisy and Democracy’ in his wonderfully measured new collection, Dennis Thompson quotes Judith Shklar, who described the politics of anti-hypocrisy as an ‘unending game of mutual unmasking’, in which everyone is bound to lose. Because democracy is a system of government that institutionalises distrust, as the price we pay for handing over so much power to our representatives, it is all the more important that we shouldn’t destroy what little trust remains, by imposing impossibly high standards. ‘We should learn to tolerate some inconsistency between the promises and performances of politicians,’ Thompson writes, ‘and perhaps even more between their private and public lives.’ If we don’t, politics will end up in the hands of the cynics and the prigs.

Thompson does not conclude, however, that we should therefore cease to worry about hypocrisy. He distinguishes between personal and what he calls ‘institutional’ hypocrisy, and suggests that in our preoccupation with the former we have forgotten that it is the latter which really matters. Institutional hypocrisy involves ‘a disparity between the publicly avowed purposes of an institution and its actual performance or function’. Thompson cites the example of the United States Constitution during the early part of its history, when the principles of liberty and equality that it proclaimed had to coexist with the practice of slavery that it also served to legitimise. This, he points out, is a far more significant feature of American politics than the parallel charge of individual hypocrisy routinely levelled against Thomas Jefferson and other champions of liberty, who happened to own slaves. Institutional hypocrisy can coincide with personal hypocrisy, but it doesn’t have to. It is also consistent with deep personal sincerity, and such sincerity will often be one of its causes. Oliver North, for instance, was not a hypocrite in any conventional sense, in that his behaviour was neither primarily self-serving nor inconsistent. It was North’s sincerity that enabled him to subvert the institutions for which he worked, and turn them against their own principles. ‘His main moral fault was not that he failed to be true to himself,’ Thompson writes, ‘but that he failed to be true to those to whom he was accountable. In his individual sincerity, he created and sustained an institutional hypocrisy.’

It is one of the striking features of the current political argument about the way healthcare in Britain should be funded that personal hypocrisy is not much of an issue. Tony Blair may not be able to bring himself to educate his children in the comprehensive system that has to suffice for most parents, but when it comes to health he is happy to take his chances with the NHS (knowing, of course, that he will be well looked after). Equally, Blair does not seem to have mixed motives when it comes to healthcare (in education a preference for selection is almost certainly concealed behind the rhetoric of universal provision). There is no reason to suppose that he doesn’t mean what he says when he talks about maintaining the NHS as a non-discriminatory system that is free at the point of delivery and treats all patients equally regardless of their ability to pay. This government genuinely wants to do its best for the NHS. Like Oliver North, the architects of New Labour’s health policy are nothing if not sincere.

The question, then, is one of institutional hypocrisy: can the NHS be true to itself if the government acts on a sincerely held belief that what it needs is an injection of private capital plus market-style competition to generate patient choice? Allyson Pollock thinks that the answer to this question is an unequivocal no. She argues that New Labour’s reforms of NHS funding, which build on but also threaten to go much further than the Tory reforms of the 1980s and 1990s, constitute a betrayal of the basic principles of a nationalised health service. The most fundamental of these principles is that healthcare should be provided on the basis of patient need, not on the basis of marketability, or cost-efficiency, or the appearance of choice. Her book is a furious denunciation of the institutional hypocrisy that results from seeing the failures of the NHS as competitive failures, rather than as consequences of the failure of successive governments to invest enough money in the service. Pollock believes that New Labour’s reforms will inevitably destroy the capacity of the NHS to meet the goal that it was ‘originally created to achieve’: a system of national healthcare that is publicly funded and, in consequence, fair.

Accusations of institutional hypocrisy can, however, be overplayed. The risk of insisting too strongly on the inviolability of a set of pre-existing commitments is that the charge of hypocrisy can give rise to its opposite, sanctimony. (One only has to think of the sanctimony of some of those who insist on the inviolability of the original purposes of the American Constitution.) Institutions must be allowed to adapt from their original purposes if the circumstances in which they operate have changed. Three things have happened which have altered the task faced by the NHS. First, demand for its services has hugely increased, in line with an ageing population and rising expectations about what healthcare should consist of. Second, the care it is able to offer has been greatly enhanced by progress in medical science. Third, the patients it treats have come to expect a certain level of personal service, as befits their experiences as consumers in other contexts. Taken together, these pressures have made it increasingly difficult to conceive of the NHS as a needs-based institution. It is no longer clear what patients need, or how many of these needs can be met, or whether their needs can be clearly distinguished from what most patients have simply come to want. As a result, the NHS has been forced to change. Needs have given way to rights, and what we have now is what a recent King’s Fund audit of the state of the NHS called ‘a set of rights to treatment, at specified and assured standards, from a widening base of diverse suppliers, public and private’.

This change of orientation may or may not be regrettable, but it cannot be said to constitute a betrayal of the NHS per se. The real question is whether an institution that adopts such a set of objectives as its guiding principles can possibly be true to them. The Department of Health recently produced a document, entitled *Creating a Patient-Led NHS: Delivering the NHS Improvement Plan*, which lays down some guidelines aimed at ensuring that the service is able to live up to its new commitments. These guidelines include injunctions to ‘treat people as human beings and as individuals, not just people to be processed’, to ‘understand that the best judge of their experience is the individual’, and to ‘provide people with the information and choices that allow them to feel in control’. The problem with these principles is that they are hypocritical at an institutional level, even if they are not hypocritical at a personal one. In any given case, it makes sense to be as understanding as possible of a patient’s personal experiences: no one is going to accuse a doctor of hypocrisy for trying to see things from the patient’s point of view. But at an institutional level, such principles tend to be self-defeating: you cannot demand that individuals should not be made to feel processed as a matter of process; you cannot insist that the patient’s experiences are what counts when it is part of a doctor’s job to interpret them. The danger of guidelines like these is that they breed cynicism. This risk is most obvious in the case of the third principle. If the purpose of the new NHS is to prioritise the patient’s feeling of being in control over any actual control, then what is on offer is institutionalised hypocrisy of the highest order. On the other hand, if the only way to give people the feeling of being in control is to offer them some real choices within the scope of a nationalised health service, the question that needs answering is how can this be done?

There are two main planks to the government’s attempts to generate real patient choice within the NHS, both of which rely heavily on the involvement of the private sector. One is the drive to introduce competition, in part by allowing private providers to compete to treat certain types of NHS patient (essentially those requiring non-emergency or ‘elective’ procedures). The other is the introduction of substantial amounts of new funding into the NHS, including private capital through the PFI hospital-building programme, thereby improving the range of services on offer. The hope is that this combination of a modernised service plus outside competition will improve the choices available to patients, giving them more treatment options, freeing up capacity and driving up standards.

The evidence for the beneficial effects of increased competition is patchy at best, and tends to rely on examples drawn from other spheres. A recent government advisory document released under the Freedom of Information Act (and brought to light by Sally Gainsbury in the journal *Public Servant*) suggested that the involvement of the private sector in the NHS needs to be expanded substantially, to the point where there are at least four competitive national suppliers, in order to emulate another ‘vibrant’ market that offers ‘innovation, increased service and value for money for customers’ – the UK market in mobile phones. There is nothing in the document explaining what makes this analogy a suitable one, or what the potential pitfalls of such a strategy might be: nothing, for instance, about whether NHS patients really are customers, given that the money to be spent and the choices to be made ultimately belong not to them but to the primary care trusts that purchase services on their behalf. Nor is there any discussion of the way competition between the NHS and these private treatment centres might work over time. The assumption is simply that competition between private suppliers must be encouraged if it is to ‘lever change’ within the NHS, and the only way to encourage competition is to open up the market.

What this document does make clear is that the attempt to introduce competition into the NHS is at a very early, experimental stage. Still, it is not much of an experiment as it stands, since in order to begin the process at all certain aspects of it have had to be prejudged. In particular, the market has had to be made sufficiently attractive to entice private suppliers. So, to start with anyway, there can’t be any real competition, because it is important not to frighten off the investors on whom the future competitiveness of the NHS depends. These investors also need to be offered substantial incentives: long-term contracts, guaranteed patient numbers, a head start over any future rivals. They get the incentives; the NHS gets incentivised. What is not clear is how this position can be reversed, as it will have to be, so that the NHS starts to get some of the rewards, and the private sector starts to feel the cold wind of real competition. There must be a danger that the advantages the private sector enjoys at the outset will persist, drawing resources and patients away from the NHS. The fate of NHS dentistry is a salutary reminder of the potential perils of this kind of mixed-market system. Of course, one way to prevent it would be for the state to intervene, and skew the market back in favour of the public sector. But if this happens, then it is hard to see what function the market has been serving.

One possible answer is that any market, however imperfect, allows greater scope for innovation than a lumbering, institutionally conservative, monopoly supplier. Even limited private-sector involvement at least offers the prospect of different types of care being made available within the public sector, for patients to experience and for the NHS to learn from. This, though, may be too sanguine a view: the beneficial effects of market innovations are not always felt by the consumer, particularly when the real client is the state. All too often, competition focuses on providing whatever service was on offer before, only more cheaply. The government is well aware of this, and has been at pains to distinguish the sort of competitive innovations that tend to follow private-sector successes in winning low-level government contracts – ruthless cost-cutting and a progressively worsening service – from what might be expected when patients get to choose where they want to be treated. In other words, don’t think about what the franchising out of basic hospital services, such as cleaning, has done to standards of care. Think mobile phones instead!

It is true that the cleaning of NHS hospitals does not provide a plausible model of patient choice, because patients are unable to choose how their hospital gets cleaned or by whom. But what about hospital food? Here we have a service that has come over recent years to combine not just the cost-efficiency of franchising out, but also the relentless emphasis on patient choice that the government insists will reveal the true merits of private-sector competition. Food has the further advantage over the mobile phone industry as a model of patient choice because it has some plausible connection to healthcare. Yet the combination of choice, cost-efficiency and franchising out in the supply of hospital food has only served to make things worse. The standard of the food was something that was always held against the old, inflexible NHS (it is one of the few things that even Pollock concedes could have been better). But like school food, which has suffered a similar fate, the inflexibility of the old days – stodgy, predictable, under-seasoned, but cooked in the hospital on the day it was to be served – looks like a boon compared to the endless array of catering options now available. My local hospital, Addenbrooke’s in Cambridge, devotes a considerable portion of its website to the improvements it has made in its food services, putting the emphasis on flexibility, choice and customer feedback. If you don’t like the primary ‘cook-chill’ options (food which is brought in and heated up on site), there are ‘enhanced ward-based kitchen services’ (this turns out to mean such things as toasters and kettles), plus the delights of the food court, with its burger chains and sandwich outlets. Addenbrooke’s has responded to customer complaints that none of this food is particularly palatable with a promise to change the appearance of the cook-chill selections, so that they look less like ‘take-aways’, and to introduce yet more choice, with more ‘restaurant-style’ options (often devised by celebrity chefs). What they can’t do is alter the basic quality of the food, because the market provides them with very few alternatives – this is the food that allows the hospital to remain within budget while making money for the suppliers.



School food and hospital food have got worse since their provision has been privatised, while private-sector food provision (in restaurants, supermarkets) has generally got better. This does not mean that schools and hospitals should try to be more like supermarkets. It means that they are very different from supermarkets, and that customer choice will not drive progress if the choices are not meaningful ones. Hospital food offers patients two kinds of choice: either to select from a range of options set by a budget they do not control, and in which the emphasis remains on cost-cutting; or to choose to spend their own money and deal directly with the private sector. It doesn’t follow that all hospital food is now bad: some hospitals still cook on site, and try to offer fresh, locally produced food, within a limited budget (the sort of thing Jamie Oliver has been trying to do for schools). But this is never the result of market pressures: it is a consequence of particular hospitals trying to do their best within the means available to them to provide a decent public service, even if it means that choice has to suffer. What the market does is to ensure that when the food is bad, it is dressed up to look good, in order to give patients and their families the feeling of being in control.

Of the 72 new PFI hospitals that have been built or are under construction, almost none has its own kitchen: food will have to be bought ready-made from the giant catering firms with which the government prefers to do business. The PFI building programme is much further advanced than plans to extend private-sector competition into other areas of NHS provision. The early signs are that some of the anxieties about what may happen elsewhere in the NHS as sources of supply begin to diversify are already being borne out here. The private capital made available by PFI is more expensive to service than equivalent public funds, but it is attractive to government because it allows the costs to be budgeted off the balance sheet of current borrowing. However, it also means that NHS trusts have to be locked into long-term contracts (over 30 years) to cover these costs, tying them into the purchase – at fixed rates – of services and facilities they cannot be sure they will need. Meanwhile, the suppliers of these services and facilities must make a profit. The hospitals that have been built under the PFI scheme tend to look attractively new and modern, but their shiny surfaces often conceal problems with basic infrastructure – bad plumbing, faulty electricity, limited space, not enough beds.

There is one big difference between PFI hospital-building and other kinds of privatisation in the NHS, however. It is not certain that the NHS needs more competition in the provision of its services, but it certainly needs more hospitals, and PFI has provided them. Many of the buildings that have been put up are not ideal, but it is likely that any public construction project on this scale and undertaken at such speed would have produced some bad buildings and generated some poor design. Given the overwhelming present demand for these hospitals, the question is whether there was a better way of paying for them. PFI projects have a tendency to look hypocritical, because they give the appearance of offering something for nothing by deferring and concealing the ultimate costs of the schemes. But whose hypocrisy is this? It is easy to say that if we want new hospitals we should be willing to pay for them through higher taxes, so that the government can retain control of the construction process. The fact is, however, that we want the hospitals but we don’t want to pay the tax. The creative accounting that allows PFI borrowing to be budgeted off the balance sheet has some obvious disadvantages, not least that it devolves the long-term commitments onto the hospital trusts, regardless of the other demands on their services. But the Treasury can hardly be accused of being self-deceived by acting in this way: Gordon Brown is not like those 16th-century Spanish monarchs who insisted that the interest payments on their debts should be left off their accounts because they found it too demeaning to be reminded of them. Brown is attempting to fund a public investment programme in a way that will satisfy not just the City, by keeping within his self-imposed borrowing requirements, but also the public itself, by keeping down the short-term costs. If this system is not ideal, it is not entirely his fault.

Where PFI can be accused of generating additional institutional hypocrisy is in the language of risk that accompanies it. One of the self-declared advantages of the scheme is that it displaces the risks of delays and overruns in building programmes onto the private contractors, whose job it is to ensure that hospitals are completed on time and within budget, and who will pay the penalty if they aren’t. These risks have been overstated. The government cannot afford to allow PFI contractors to suffer serious losses, because the entire programme depends on maintaining the confidence of investors. Were that confidence to go, the costs of borrowing would inevitably rise. (As Pollock points out, one of the reasons the government eventually decided to reimburse investors in Railtrack was because ‘it was made clear that future PPP projects would otherwise cost a great deal more, to offset what investors would then see as greatly increased risks.’) If anything, the risks have been displaced not from the trusts to the private contractors, but from the government to the trusts. When contractors fail in their obligations, it is the trusts that will have to decide whether to stick to the original agreement, or bear the costs of changing contractors. It is also the trusts that have to manage the possibility that they will be paying in years to come for hospitals that are no longer needed, because of competition elsewhere in the system (not just from private suppliers but from other hospitals and from non-hospital based services). This dispersal of risks is of a piece with the government’s desire to devolve fiscal responsibility onto individual trusts, so that they can assume control of their own budgets and therefore take responsibility for the services they offer. The health minister, John Reid, recently stated that he would no longer answer questions about operational matters at foundation hospitals because the point of such hospitals is that they must answer for themselves. PFI, foundation hospitals, private-sector competition are all part of making sure that individual providers understand that the quality of healthcare provided by the NHS is their responsibility, and the risks of failure are theirs as well.

This devolution of responsibility has not, however, been characterised by the government as a dispersal of the risks of failure. Instead, it has been dressed up in the language of devolved public ownership. Although foundation hospitals exist primarily as a vehicle for introducing competition into the system – by allowing money to track performance indicators, including patient choice, instead of requiring that budgeting continue to follow existing needs – they have been presented as vehicles of local democracy. Pollock quotes Ian McCartney, chair of the Labour Party’s National Policy Forum, on foundation hospitals: They ‘cannot be described as “elitist” in any real sense of the word . . . They lock the public resources of the hospital into ownership by the citizen in the community: owned by the community, for the community, serving the community . . . This is public ownership which means exactly that: owned by the public.’

What it actually means is that residents in areas covered by these hospitals get the chance to register as ‘members’ of the trust, allowing them to vote for a board of ‘governors’ to whom the directors of the trust are nominally responsible. Out of more than two million people served by the first ten such hospitals, 34,000 registered as members and (including hospital staff) only 20,000 voted in elections for governors. Pollock must be right when she suggests that real control of these hospitals lies with their chief executives and other directors, with the large private companies that will provide many of their services, and with the NHS regulator, whose job it is to issue licences to foundation hospitals and to determine the range of services they can offer. The level of accountability of these institutions to their boards of governors is likely to be very limited, and the mere fact that the governors have been elected does not confer any particular legitimacy on them, especially if no one bothers to vote. All it does is further discredit the legitimate institutions of representative politics, by dissipating the notion of electoral accountability.

Pollock tries to tie all this together, by arguing that every failing of the new NHS follows from its having abandoned its founding mission to provide a genuinely public service. She is part right, part wrong. She is right to suspect that the marketisation of healthcare provision is driving a range of changes, many of which are being passed off as something else. But she is wrong when she concludes that all such changes are equally unacceptable, because they all represent a deviation from the core principles of the NHS. Her book doesn’t take sufficient account of the political and structural challenges faced by any government when dealing with popular pressure to improve NHS care, and to modernise it. Some changes were inevitable, and more money had to be found from somewhere. What is unacceptable is the institutional hypocrisy that has accompanied these reforms.

This has not been confined to the NHS itself. Pollock’s book contains a barrage of general statistics, and it is mercifully free of the individual patient histories that are such a hateful feature of modern electoral politics (though she devotes a considerable amount of time to tracking the private-sector careers of various health policy advisers to the government). Nevertheless, the most compelling part of her account is also the most personal. She describes in detail the campaign that was launched against her by members of the House of Commons Health Select Committee during 2002, most notably by the Labour MP Julia Drown, who insisted on inserting into the committee’s report on PFI a series of comments rubbishing Pollock’s research and the work of her unit at University College London, and suggesting that Pollock’s personal antagonism to NHS reform made her incapable of rational analysis of the data. If there is any truth in this (and there are moments when Pollock does seem to prejudge the evidence, particularly in her hostility to any non-British forms of healthcare funding), it is not clear that Drown is the person to be pointing it out.

Drown has published her own research on PFI, which is available on her website. She and a co-author wrote to NHS chief executives in 2001, canvassing their views on PFI. The responses they got divide pretty evenly between those who view PFI favourably and those who do not. It is noticeable that the favourable responses tend to concentrate on the benefits of having new hospitals, whereas the unfavourable responses tend to concentrate on the dangers of paying for new hospitals in this way, so that it is not clear that like is being compared with like. This is not, however, the conclusion that Drown draws. Instead, she notes what the chief executives have to say about the opportunities and threats that PFI faces. Chief among the opportunities is the prospect of generating ‘positive publicity’ for PFI, and chief among the threats is the risk of ‘negative publicity’. The paper concludes by pointing out that the most important factor in achieving success for PFI hospitals will therefore be securing good publicity. It also suggests that for those chief executives who have expressed misgivings about how PFI is working, ‘successful application of the PFI may also depend on changing their views.’ The way forward, in other words, is re-education.



It is trite and faintly ridiculous to compare the political practices of New Labour to Stalinism. In the case of healthcare policy, however, it is appropriate, if only because the government likes to accuse the old NHS of having suffered from Stalinism. It is routine to hear New Labour apparatchiks call the unreformed NHS a ‘Soviet-style’ system. Pollock cites the New Labour mantra: ‘The NHS is a multibillion pound business. With over a million employees it’s the second largest employer after the Red Army. No one can run a business that size. No wonder it’s bureaucratic and inefficient.’ In fact, what seems to have most irked successive governments about the old NHS was not its monolithic and centralised control structure, but its informality, the way that so much was casually decided between senior consultants and hospital managers, so that nothing was properly costed and complete records were not available. Too much depended, as in so many professions, on who knew who, so that no one was ultimately accountable for their actions, and managerial oversight was impossible. The present government has been at war against this kind of complacency ever since it came into office, and there is only one part of British public life where such practices have been allowed to continue unchecked – within the government itself. Blair runs his own administration much like a 1970s hospital, with everything depending on finding yourself on the right sofa at the right time, with as little as possible written down, no proper minutes, everything geared towards reaching a workable consensus among colleagues who understand how things work on the inside. This, Blair would say, is the only way to get anything done. It is the hypocrisy that is so nauseating.

The difference, Blair might also say, is that we have an opportunity to vote him out of office if we don’t like what he does, whereas until the NHS was reformed no one could do anything about badly run hospitals. But the general election we are about to endure offers no more realistic prospect of holding Blair to account for his style of government than the pseudo-elections he has introduced for hospital trusts offer the prospect of restraining the worst of the new hospital managers. Who are we meant to vote for? It is true that Tory health policy offers the prospect of less institutional hypocrisy, since there would be less pretence that patient choice and private-sector competition were simply the best way to maintain universal standards of care. But that is because Tory health policy would mean the end of universal standards of care, as better-off patients passported their way out of the system, taking some of the best doctors and nurses with them. I am not clear about the implications of Liberal Democrat policy on the NHS, and find it hard to care.

In many ways the most attractive realistic alternative to government health policy has come surreptitiously from Gordon Brown, via Ed Balls, via Robert Peston, in his book *Brown’s Britain*. Here it is revealed that Brown has serious misgivings about extending competition and private enterprise unthinkingly through the public services, both because of what it might do to what’s left of a public service ethos, but also because of what it has done where it has been tried, particularly to NHS dental care. Yet Brown remains obstinate in his defence of PFI, as the most efficient way of generating some of the funds needed to modernise the fabric of the NHS.

Brown emerges from the book as a hypocrite, not least because of the way the book enables his views to be known without being directly attributable to him, though this can be put down to the unavoidable duplicities of democratic politics. More serious is the evidence of Brown’s curiously cosy relationship with the right-wing press (particularly the *Daily Mail*), his obsessive secrecy, his over-reliance on a few close advisers, his tendency to micromanage, and his occasional grandstanding (the Laura Spence affair is quietly passed over by Peston). Brown shares with Blair a reluctance to write anything down. But in Brown’s case this stems in part from a recognition that once he has made a long-term commitment, it is important to stick to it, which means it is also important not to commit oneself too soon. This makes him cautious, careful, crabbed and frequently vindictive when things go wrong. But it also means he is sceptical of easy solutions. He appears to share none of Blair’s utopianism about unified public/private solutions for healthcare provision, and would have no time at all for the wishful thinking that passes for health policy research in the prime minister’s circle. At least when Brown commissions a piece of research – like the Treasury assessment of the five economic tests for Britain’s entry into the euro – it is serious, even if the motivation behind it is almost entirely self-serving. He is altogether a more serious politician than Blair: more serious about political ideas, but also more serious about the limits of mere ideas to reshape the world in their own image.

Despite all his hypocritical and self-serving qualities, Brown’s steady, pragmatic commitment to a version of broadly egalitarian public service funding makes more sense than anything Blair has offered in eight years of government. Most of the achievements of this government have been Brown’s. Most of the mistakes have been Blair’s. All in all, it is Brown I would like to vote for. But in the absence of primary contests for party leaders before a general election, I can’t. The quasi-presidential powers that Blair has acquired within an ostensibly parliamentary system of government, which have left him more or less impregnable at the polls, is the worst institutional hypocrisy of all.

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**Letters**

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I had not long finished reading David Runciman’s cautionary article on the commercialisation of the NHS ([*LRB*, 21 April](https://www.lrb.co.uk/v27/n08/david-runciman/institutional-hypocrisy)) when I happened on a few lines in the newspaper to the effect that a man of ninety who was a patient in a hospital somewhere in the North of England had been left lying on a mattress on the floor because the lease had run out on his bed. This seemed to be taking commercialism rather beyond any acceptable limit, even for those of us who are not fanatically opposed to the Private Finance Initiative as a way of raising ready money to pay for new hospital buildings. If local hospital trusts find it good practice to rent beds from outside rather than buy and own them, it can only be because it works out cheaper in the long run, the long run being the prime consideration if laying out more money in the short term involves you in having to raise it from somewhere or somebody who is unwilling to pay up. The only reason we have the PFI in the first place, as Runciman indicates, is that we are presumed by New Labour to be so unwilling to pay more taxes to fund new hospital building from public sources that we might decide to vote for the other lot when the day comes, as it’s just about to. It may of course be the case that the story about the floored nonagenarian up north isn’t true, but was offered to the press as one of those ‘hateful’ – Runciman’s word, and how right he is – individual cases of which so much is made at election time. The fact that the Tory Party seems not to have picked up on it makes me wonder whether even they were suspicious of its authenticity. They have instead, at least where I live, put out an election poster claiming that since New Labour took charge of the NHS, we’ve had three times as many MRSA bugs in our hospitals as when the Conservatives had charge of them – these nasty little foreign bacteria are presumably the medical equivalent of illegal immigrants. The long-term answer to the problems of the NHS may in any case not lie with governments of either colour. If commercialisation is held to be the solution why not hand it over to what is patently the most successful commercial organisation currently in our midst? ‘This does not mean that schools and hospitals should try to be more like supermarkets,’ Runciman writes. But why not? Given that Tesco appears to be able to make £2 billion honest profit in a single trading year, it’s surely time they were invited to start building a Tesco wing for the local hospital rather than opening yet more of their awful convenience stores.

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David Runciman’s account of the injection of choice into the NHS doesn’t mention ‘Choose and Book’, a project intended to transform the process of allocating outpatient appointments. Instead of being put on a waiting list and subsequently given a date for an appointment, patients will be able to book appointments with the help of their GP, through a call centre or via the web. Not only will they be able to pick a date that suits them, they will be offered a choice of hospitals, including private ones. The project made the headlines when the National Audit Office reported that although it had been hoped that 205,000 patients would have taken advantage of the new system by December 2004, only 63 patients had used it.

Some of the rhetoric that surrounds this initiative is illustrative of the institutional hypocrisy Runciman describes. The Choose and Book website boasts that you will get your appointment faster. But getting your appointment faster doesn’t mean that you will be seen sooner. Under the present system a patient seeing their GP in, say, April might be told in June that their appointment will be in July. With Choose and Book the patient will be told the appointment date in April, but it’s actually less likely to be as soon as July. The project is mentioned in a section of the Labour Party manifesto called ‘Choosing Not Waiting’, but as a result of the constraints involved in offering choice and guaranteeing availability patients will in fact have to wait even longer to be seen.

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It is true that the subsidy system which has been used to allow the construction of foundation hospitals leaves much to be desired, but the principle that patients, former patients and staff should elect the boards of governors of foundation hospitals is an excellent one and should be extended to all NHS hospitals. David Runciman is wrong to allege that these boards of governors have no power. They are able to appoint or remove non-executive directors, and to decide their pay, allowances and other terms and conditions.

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David Runciman hasn’t got the economics of PFI quite right ([*LRB*, 21 April](https://www.lrb.co.uk/v27/n08/david-runciman/institutional-hypocrisy)). More than once he says that Labour has looked to the private sector for additional capital. That argument was widely used by New Labour ministers in the mid-1990s to bring around laggards in the constituencies. The trouble is, it isn’t true (and that’s why you never hear them say it any more). Under PFI, the private sector finances capital expenditure, i.e. borrows the money for it, while the public sector funds it through the annual payments it makes to PFI consortia. Any additional capital is thus paid for by the public sector alone. PFI is a mechanism by which the government borrows through an intermediary (at a higher rate of interest than if it had borrowed in its own name). Allyson Pollock shows in *NHS Plc* how the high costs of PFI-related debt servicing have led to major reductions in NHS capacity: since 1997, 12,000 NHS beds in England have closed (5 per cent of the UK total), many of them in hospitals procured under the PFI. The first 14 PFI hospitals had their budgets cut by 25 per cent, which they mostly managed by hiring fewer nurses. All Labour’s arguments in favour of PFI now turn on risk transfer, which Runciman rightly takes a jaundiced view of as there is little evidence of the private sector assuming any real risk. The PFI debt bubble and associated contractual problems are already unravelling: witness the Jarvis schools PFI scheme in Brighton.

*Pace* Runciman, there is every reason to suppose that Blair does not mean what he says when he talks about maintaining the NHS as a non-discriminatory system that is free at the point of delivery. As Pollock points out, he is the first prime minister to introduce time limits on NHS care, and to introduce charges for personal and nursing care in NHS hospitals.

**Neil Vickers**  
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I note from David Runciman’s article that the health secretary no longer answers questions about the operations of foundation hospitals in view of their relative independence. Do we know how much John Reid’s salary has been reduced to reflect his reduced responsibilities?

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