THE HEWITT REVIEW – EMBEDDING THE NEO-LIBERAL CANON

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As could be expected both media and the healthcare policy community were almost wholly supportive of Patricia Hewitt's Review into the autonomy and accountability of the newly-created Integrated Care Systems (ICSs). Even the NHS Support Federation, in a somewhat threadbare appraisal, thought there was much to recommend it, and that as a "vehicle for real reform" it did not go far enough. More importantly it told readers that the Review offered "no support for the minority view that ICSs are a trojan horse for planned Americanization". This is, however, entirely wrong, as the the key component of the Review – that of decentralization of healthcare management and organization – is a central tenet of the neo-liberal canon, and hence of global market formation, and indeed in all aspects the Review adheres to the imperial narrative and to the imperial vision.

INTRODUCTION

The news that Patricia Hewitt was to lead a governmental review of ICSs inevitably prompted memories of her period in office as Health Secretary and subsequently as all-purpose advisor to private equity, pharmacy chains and private healthcare corporations. Born, according to a *Health Service Journal* editorial, from a series of text messages between Hewitt and the current Chancellor, Jeremy Hunt, the Reviews' remit was to consider how to give local ICS leaders greater control while greatly reducing the number of national targets for which the new bodies are accountable.

Hunt, himself the longest serving Health Secretary, had, the editorial argued, unfinished business with the NHS and had no intention of missing the opportunity to make his vision of greater local autonomy and fewer targets a reality, and added that this "is very much a personal, and not an especially political, crusade for Mr Hunt". Couched in these terms, one could be forgiven for thinking it was largely a technical exercise and devoid of controversy. The Review is, however, very much part of a political crusade and one of significantly greater duration than Hunt's term of office.

REVIEW

As mentioned, the main aim of the Review was to establish increased autonomy, productivity and systemic ways of working for the 42 Integrated Care Systems (ICSs), enacted into law by the 2022 Health and Care Act. This would be achieved by significantly reducing the number of national targets – the published Review recommended a maximum of 10 – for which the organizations would be accountable for as well as enhancing collaboration on a systemic level through, for example, mutual learning and support between the commissioning Integrated Care Boards (ICBs) and the range of providers available within both health and social care.

Resources should, the Review emphasized, be increasingly shifted towards prevention, population health management and tackling health inequalities, and underpinned by the use of "timely, relevant, high-quality and transparent data". Regulation would be increasingly devolved to a light-touch national accountability framework overseen primarily by an enhanced Care Quality Commission (CQC), itself a largely independent body, which would also assess the level of mutual accountability between system partners as well as on cultural change and integration.

The Review also advocated recurrent multi-year funding arrangements with "significantly greater financial freedoms" for the 10 most advanced and best-performing ICSs in order to "determine allocations for services and appropriate payment mechanisms within system boundaries", adding that "the NHS payment scheme should be updated to reflect this". A further recommendation was that ICSs should be given the freedom to draw up their own payment systems.

Given the Reviews' genesis the Government was inevitably fully behind it, stating that "ICSs are vital to the future delivery and improvement in health and care and the government is committed to doing all it can to support their success'. The *Health Service Journal*, disingenuous as ever, tried to convey a measure of hesitation and democratic process on the government's part but any related to minor caveats. Interestingly, however, while most reports highlighted the terms 'autonomy', 'local leadership' and 'freedoms, only the Integrated Care Journal places the Review within its fullest context; namely the decentralization of healthcare management and organization.

CONTEXT
The concept is worth unpacking.

As Gowan pointed out, the United States' bid for world dominance was based on two interlocking strategies; namely global market formation under its strict stewardship and the requisite neo-liberal domestic transformations.[i] Such transformations involved a shift within states in favour of creditor and rentier interests, the subordination of productive to financial sectors, and moving wealth, power and security away from the bulk of the working population.

The two elements reinforce each other. The shift in domestic social power relationships "strengthens the constituencies favouring globalization", while the forces favouring globalization "will favour these same domestic transformations". States resisting such changes would be increasingly marginalized within an evolving US-led global economy, and both processes "favour the transnational expansion of US economic and political influences".

And, as far as healthcare was concerned, the earliest, and perhaps fullest, expression of the above-mentioned canon can be found in the World Bank's[1] 1993 report, 'Investing in Health', certainly for its initial roll-out in Latin American, and subsequently African and Asian, states.[ii]

As may be expected, the Banks' stated aims were distinctly progressive and included alleviating poverty, accelerating development, and making healthcare accessible to the broad population. These were, however, to be achieved via "greater diversity and competition in the provision of health services, by decentralizing government services, promoting competitive procurement practices, fostering greater involvement by non-governmental and other private organizations, and regulating insurance markets".

As such the aims required a basic reordering of state institutions - stripping them of redistributive functions, the re-determining of healthcare as a commodity and, logically, the moving of services into the direct sphere of private capital accumulation in order to serve the global economy. And, in order to facilitate global investment, the reforms had, as Laurell pointed out, "a striking uniformity".

LEVERS
Owing to the fragility of public infrastructures in Latin America, and other regions of the 'South', transformations in public healthcare could also be built upon artificially-created debt crises and Structural Adjustment Programmes initiated by the World Bank and the International Monetary Fund (IMF). In Chile, even starker options were available. In contrast to the socialist premier, Salvador Allende, who wanted to extend the national framework, the military regime – under instructions from Chicago School economists – began a drastic reduction in public services, extending the private healthcare system, and devolving the national framework into 26 autonomous health authorities.[2]

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[1] The Bank is, alongside the International Monetary Fund (IMF) and the US Agency for International Development (USAID), a chief financial instrument of US imperialism.

[2] Chile was indeed the first country in Latin America to initiate a major effort to decentralize its health system.

As mentioned, the globalizing reforms had a strict homogeneity which extended to the accompanying narrative of decentralization. This included the encouragement of local freedoms, with the devolved economies offering more responsiveness to their immediate populations as well as promoting attempts to increase equity, efficiency, participation, and intersectoral collaboration, thereby improving health outcomes.

Contrary to any claims of advancing democracy, as a result of decentralization the principles of universality and pooled risk are replaced by those of individualism and privatization, as well as removing national co-ordination and oversight. Equally, the process fragments both the public sector and the labour movement, and, as the US Agency for International Development pointed out, decentralization in Chile facilitated the formation of private health plans and the introduction of US Health Maintenance Organizations (HMOs) and "may also be interpreted as a step in the comprehensive plan to privatize all health care in the long run".[3][iii]

ENGLISH HEALTHCARE ECONOMY

Observers will recognize the extent to which the Bank's prescriptions for global healthcare have been reproduced within England. They will also notice that, with a few modifications, such as decreasing national targets and other forms of 'red tape', an identical narrative for decentralization has been adopted within the Hewitt Review.

The government's terms of reference for the Review, for example, includes, "how to empower local leaders to focus on improving outcomes for their populations, giving them greater control while making them more accountable for performance and spending", while Hewitt herself said that, "ICSs provide the biggest opportunity in a generation to improve health outcomes, transform health and care services and reduce health inequalities". And, inevitably, the Review will provide greater legitimacy for this part of the overall process.

'LOCAL' LEADERSHIP

Equally, under cover of this narrative, the same aim of facilitating global investment is being both pursued and achieved.

Much of this became increasingly evident even before ICSs became statutory. In February 2022, for example, a leaked report shared with ICS CEOs by NHS elective care chief, Sir Jim Mackey, showed that the giant consultancies, Deloitte, EY, McKinsey, PwC, and KPMG, would "set strategy, provide analytics and help lead the creation of ICS elective recovery plans". The consultancies were also "expected to form the start of a multi-year planning approach for the new organizations".

Far from any notions regarding the strengthening of 'place' or local powers of decision-making, the above-mentioned companies serve as chief conduits between government and Fortune 500, and while the plans had to be signed off by both ICS and NHS providers' chief executives, it seems unlikely that any disputes arose.

Indeed, the composition of 'local' leadership within ICSs offers further proof of the near symbiotic relationship between state and capital. So far two strands can be identified.

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[3] It is also worth mentioning that several studies from Latin America showed that funding did not always follow the moves to a more local basis, and led to increased user fees and the adoption of private insurance, thereby exacerbating already existing social and spatial inequalities. See, for example, Willis K & Khan S, 'Health Reform in Latin America and Africa: decentralization, participation and inequalities', Third World Quarterly, Vol. 30, 2009. Such studies invariably mention decentralization and privatization in the same breath. See, for example, Bach S, 'Decentralization and privatization in municipal services: The case of health services', International Labour Office, Geneva November 2000.

Firstly, as the Kings Fund has described, an old guard of tried and tested leaders offering "air cover" while ICSs bed in. Rather than any local affiliations the posts should be seen primarily in terms of stabilizing the new regime and as reward for demonstrating career-long commitment to global market formation.

These include:

- Sir David Nicholson – Interim Chair of Hereford and Worcestershire ICS. Department of Health, World Bank, KPMG, Chair of Universal Health Coverage Forum of the World Innovation Summit for Health, and Senior Advisor for the Evercare Group which operates as a healthcare delivery platform in emerging markets across Africa and South Asia.
- Sir Chris Ham – until recently Chair of Coventry and Warwickshire ICS. Ham's career has also included Director of the Strategy Unit in the Department of Health, advisor to the World Bank, and consultant to a number of governments. He is also currently an advisor to Carnall Farrar, a healthcare consultancy run by former members of McKinsey, KPMG, GE Healthcare and NHS London.
- Dr Penny Dash – Chair of North London ICS. Director of Strategy at the Department of Health, Boston Consulting Group, and currently McKinsey's Senior Partner and Lead for Healthcare, Europe.
- Sir Neil McKay - Chair of Shropshire ICS. Formerly Chief Executive East of England Strategic Health Authority, McKay also set up the Strategic Projects Team which facilitated the private management of Hinchingbrooke NHS hospital, and worked with GEM Arden, an NHS 'support' organization whose partners include UnitedHealth, KPMG, McKinsey, and Deloitte. He has also acted as consultant for GE Finnamore, a company owned by US giant, General Electric.
- Patricia Hewitt - Chair of Norfolk and Waveney ICS. Former Secretary of State for Health, adviser to AllianceBoots/Cinven, and Senior Adviser to FTI Consulting and to Sutherland Global Services, a technology and 'transformation' company supporting Fortune 500 clients in 30 countries.

Secondly, a younger cadre schooled largely by US insurers and consultancies. Many of these have, for example, passed through the 'Nye Bevan Suite' – the irony is surely enjoyed – of the NHS Leadership Academy, the curriculum of which is mainly designed by KPMG.

Similarly, beginning in January 2018, NHSE appointed UnitedHealth, the largest US healthcare insurer, and PwC to deliver a "major capabilities building programme" to "facilitate the move to whole system working" for the most advanced ICSs, including those in Birmingham, Warwickshire, Northumbria, West Yorkshire, and Cumbria, and involved everything from care redesign to financial management, effective leadership, integrated contracting, governance and delivery, as well as building sustainable, value-based, strategies.

For the programme United fielded its most senior partners and directors, all of whom were "experienced leaders in complex business systems". In all stages of the programme, ICS leads, hospital CEOs, finance officers, and local authority chief executives, worked alongside the US corporations, though as the Director of Commissioning for the West Midlands, Alison Tonge, pointed out, it was "UnitedHealth and PwC, who led the sessions".

FURTHER 'FREEDOMS'

The Review's insistence on widespread 'freedoms' - both in terms of spending and operational practice - for the most advanced ICSs affords the opportunity to pursue UnitedHealth's curriculum. Such systems are likely to include those in Nottingham and Somerset, where US insurer Centene and UnitedHealth have acted as the "engine room of transformation" within the respective areas.

Over a two-year period beginning in early 2016, Centene effectively designed what would become one of England's first ICSs. This involved an actuarial analysis - necessary for an insurance

system - and 32 workstreams including those on patient pathways, population health management, social care integration, IT services, provider payment models, together with governance and contract design.

The company's future role in the county is spelt out in a Nottingham City Clinical Commissioning Group (CCG) document from December 2016,[iv] whereby the 'integrator' - Centene - would be the middleman between the funding/commissioning bodies and the range of providers, and would act as an "impartial ICS manager, accountable for all services, data reporting, contracts, and other functions to manage the financial risk effectively". It would also provide investment via capital and loan guarantees and risk-sharing would be involved. In other words, the relationships are identical to those of a US HMO.[4]

PREDICTIONS

Writing in 2007, Nuruzzaman categorized the World Bank's health reform package as comprising four elements; namely the introduction of private health insurance, user fees for services, a role for private providers and non-governmental organizations (NGOs) in service provision, and the decentralization of health services management.

A main feature, and strength, of these are that they are mutually reinforcing. As mentioned, decentralization affords diminished national oversight with control assumed by capital via a policy elite with myriad links to private health providers, insurance corporations, and global forums. At the same time, the proposed increased powers for the Care Quality Commission (CQC) confirms a decreased, regulatory role for the state – and entirely in keeping with the canon.

Coupled with ongoing and significant reductions in public budgets, the new ICSs will assume private insurance principles and further globalizing instruments such as the limited package offered by Universal Health Coverage promoted by the World Bank. David Nicholson, for example, has written extensively on this topic, and it tallies with the notion of 'core responsibilities' introduced by the 2022 Health and Social Care Act, which involves limited rather than universal coverage and, as Roderick & Pollock point out, will result in user charges and other forms of insurance-based top-ups. A trial in Worcestershire could certainly go under the banner of 'local freedoms'.

Other private insurance methods are already in place, for example in membership plans offered by some NHS Foundation Trusts in partnership with private companies, and the new regional organizations, far from reflecting increased democracy or local participation, are drawn up by a mix of US corporations and a fully compatible policy community.

While many continue to argue that the Americanization of English healthcare is a minority view, its contours are increasingly evident and in all aspects the Hewitt Review faithfully reproduces the imperial vision. Fragmentation is a key mechanism in destroying the strength and solidity of the public framework and in securing the English healthcare economy's place within a global market. As former NHS England Chief Executive, Lord Stevens, told an audience of US government officials and investors in New York in 2004, the "era of English exceptionalism is over", and while the process has taken longer than in Latin America and Africa, the principles and strategies deployed are largely identical.

[4] It's worth noting that the above-mentioned document is the only that was publicly available which gave the full five scenarios of the 'future system architecture' for ICSs – other presentations, for example from the Kings Fund, only gave the, undoubtedly less controversial, first two. The document has since been removed.

[i] Gowan, Peter. ‘The Global Gamble: Washington’s Faustian Bid for World Dominance’, Verso, 1999.
[ii] World Bank. ‘World Development Report 1993 Investing in Health’, Oxford University Press, 1993.
[iii] Latin America and Caribbean Regional Health Sector Reform Initiative. ‘Enhancing the Political Feasibility of Health Reform: The Chile Case. June 2000.
[iv] Nottingham City Clinical Commissioning Group. ‘NHS Clinical Commissioners: Core Cities’, December 2016.