The Henry Cohen History of Medicine Lecture

'Seventy Years of the NHS: its Money, Medicine and Management'
Professor Nicholas Timmins, Visiting Processor in Social Policy at the London School of Economics and in Public Management at King's College, London

Held on Tuesday 21st November 2017

Back row (l-r): Mr T West, Mr Max McCormick, Dr N Beeching, Prof J Earis, Prof P Clegg, Mr D Machin, Prof C O'Mahony, Prof G Kemp, Dr C Evans, Prof P Davies, Mr R Franks, Dr W Taylor
Front row (l-r): Mrs G Latham, S Dawson, Prof E Comerford, Prof H Scott, Prof N Timmins, Prof S Sheard, Dr A Franks, Dr S Evans

Money, of course, we are all interested in. Medicine, naturally, is fascinating. But management …. who wants a lecture on management? A subject that is as dull as ditchwater.

But I will do my best to make it relevant to the other two. And at least mildly entertaining. Because management is one part of the two iron triangles, so to speak, that define how the NHS operates.

Or perhaps not so much triangles as triskelions - the three-legged symbol of the Isle of Man, which is fitting enough, seeing as it is just across the water.

In the first of these (see Slide 2) money is one point, or leg.

The other two are quality and access. The quality of care, which includes safety, is one critical element of the NHS. But quality is at least in part dependent on the resources – the amount of money available. And quality on its own is of limited use without access – waiting times. And access, of course, also depends on the money. And so on, round and round.

When the three points, or three legs, are in balance the health service functions well. It fairly bowls along.

And indeed the motto that goes with the Isle of Man's symbol is "whichever way you throw it, it will stand". Leave one of those legs short, however, and it falls over (see Slide 3).

And the same, I contend, goes for the matching triskelion, of money, medicine and management. Get those three right and you have a health service to be proud of. Get them wrong and it will be contention of this lecture that we have far too often, and for far too long, got them wrong and it does not function well. Or at least not as well as it should.

But enough of this rather unconvincing and unlikely anatomy!

Now, I should emphasise near the outset that when I talk about management, I am mainly going to talk about hospital management – not general practice.

So …. Where else to begin? Well, on July 5 1948, seventy years ago next July – as I am sure you all know - the National Health Service was launched. Its launch came with this leaflet (see Slide 4). And the leaflet says it all. In language of such crystal clarity that one wishes the modern civil service emulated it more often.

The NHS, it says "…. will provide you with all medical, nursing and dental care … There are no charges, except for a few special items. There are no insurance qualifications.
"BUT …. It is not a charity. You are all paying for it, mainly as taxpayers, and it will relieve your money worries in time of illness. "
Which brings me to the first part of this lecture – THE MONEY. No charges, no insurance qualification. But not a charity.
Now ….. Time forbids going into the origin of all of this.

But the National Health Service that was created by Nye Bevan – the artist in the use of power as Kenneth Morgan once so memorably described him – differed with what went before in many ways, including nationalising the hospitals. But for the purposes of this evening, the key change was to the funding base.

What had gone before was a form of social insurance – Lloyd George's famous "ninepence for fourpence". In return for the employee's four pence the employer had to put in three pence, while the state provided tuppence – all old money of course – which, from 1911, provided access to a "panel" doctor. And that was a spectacular advance on what had gone before.

It formed part of what has been dubbed "the ambulance state" – the precursor to the modern, post-war, welfare state.

An "ambulance state" because while the contributions were compulsory, it was anything but comprehensive. The better off were excluded, as were the unemployed, and spouses and children. And hospital care was not included.

So the big switch that Bevan instituted was that the NHS in future was to be funded out of general taxation – and if anyone wants to argue that national insurance, or "the stamp" played any significant part in this, I'll happily take you on later.

Now ... The switch to general taxation has been both a great strength and a weakness of the NHS. Its strength has been that the NHS has been available to all regardless of contribution, the odd prescription charge aside. No questions asked. Treatment according to need, not ability to pay. Its weakness is illustrated by this slide (see Slide 5). And it is one of only two this evening with any numbers in it.

It is incredibly busy. And if you can't read it from the back, don't worry. It is not the individual numbers that matter but the picture they paint. These are actually health expenditure figures from 1955, not NHS expenditure, so they include things like public health. And they are for the UK, not England. But the picture would be the same for those.

And what it shows is that the growth in health spending has shot up and down like a demented yo-yo. On average, spending has risen by 3.8 per cent a year in real terms - in other words with inflation, or the GDP deflator, stripped out. But just look at those bars. They shoot up and down. From almost 12 per cent real at their peak to minus three per cent. And even the five year rolling average – which is the black line – has dramatic peaks and troughs.

Some of the variation is in fact explicable. At times it reflects the state of the economy. Broadly speaking, we spend more when times are good, less when they are bad – although often with a time lag both ways. And in places there are peaks that reflect certain reforms. There is a peak in the early 1990s, for example, as the Conservatives pumped money in to ensure that their first version of the purchaser/provider split - the so-called NHS internal market - did not crash and burn on day one. But the essential point is that it is not consistent. It varies wildly. And even when Gordon Brown, at Tony Blair's insistence, put sustained money into the NHS – seven per cent real for five years – there are plenty of people, me included, who think the money might have been spent better if it had been five per cent real for seven years, rather than the other way around.

And wild variation cannot be good for any sensible sort of planning. Look at this through the eyes of the financial director of a large FTSE company. If you had any idea that that was how your revenue stream was going to perform, you would probably quit on the spot. Judging the job to be impossible. But the NHS has had to manage this. And in many ways, given the scale of the challenge, has done so rather well.

Now …. I don't have the PowerPoints with me. But if you had a similar graphic for the bigger European countries that use social insurance to fund their health care, you would still see a lot of variation. But the swings up and down would be appreciably less dramatic because changes to the social insurance base tend to take longer to settle and negotiate - rather than the funding being decided, most often annually, at the stroke of a Chancellor's pen. So certainly up to 2008 and the arrival of the global financial crisis, social insurance funding has tended to be more stable.

So general taxation has been a good. But it has had its weaknesses. And it is worth recognising that. Not that I think that remotely makes the case for changing the funding base to a social insurance one. There are powerful arguments against, which I could rehearse in questions.

Now … as any skillful accountant will tell you, there is, of course, more than one way of looking at the money. Another is share of GDP. Which in plain language is what proportion of the national income do we spend on health? And this chart shows it (see Slide 6). It too has risen. Far from consistently, because there are up and downs there too. But if you look at what is going on currently – the downturn at the end – and what is projected to happen out to 2020 - that tells you pretty much all you need to know about why the NHS feels under such pressure at the moment.

And why one of the legs of the triskelion being squeezed or shortened is starting to have an effect on the others. Right now, waiting times. In future, if this goes on, quality.

And of course you can look at it purely in cash terms. Without allowing for inflation that is pretty meaningless. But in its first full year of operation the NHS – and these again are UK figures – spent £11.4bn. In fiscal year 2015 it spent more than £138bn. Twelve times as much. But, while not the best number to look at, it still makes a point. For back in 1948 there was a widespread assumption that the NHS would have to deal with a backlog of untreated need, but that after that expenditure would stabilise.

Not that I am convinced that Bevan ever believed that. 'We never shall have all we need,' he declared at the beginning. 'Expectation will always exceed capacity …. The service must always be changing, growing and improving; it must always appear inadequate'. That there was a backlog of needed care is not in doubt. There was a deluge of it.

John Marks, who qualified as a doctor on the day the NHS started, and who went on to be chairman of council of the British Medical Association, recalls doing locums in general practice where – and I quote – "women arrived with prolapsed uteruses literally wobbling down between their legs that were held in place with these hideous cup and stem pessaries. "And men walking around with trusses holding these giant hernias in. And they were all like that because they could not afford to have it done. They couldn't afford to consult a doctor let alone have an operation.

"And at the same time as the NHS arrived medicine was starting to do more," he says, "I saw penicillin come in as a medical student, and as a houseman I was one of the first people to treat TB meningitis with streptomycin. The child survived. Admittedly it remained severely disabled, but it survived. Before that it was a 100 per cent death rate."

And that captures so much of the NHS's early years. The backlog of unmet need and the beginning of the mighty pharmaceutical and technical revolutions. First in the 1950s and 1960s - which saw the first pharmaceuticals capable of treating mental illness, then the first truly effective treatments for high blood pressure and diabetes, the arrival of mass vaccination for polio and much else, the dawn of the contraceptive pill and of Valium – "mother's little helper" in the Rolling Stones track, or "the happiness pill" as drug manufacturers were in those days allowed to market it.

And on the surgical and technical side, the sixties saw the first hip replacements, followed by dialysis, and then kidney, heart, liver and lung transplants - while the seventies saw the arrival of Magnetic Resonance Imaging and CAT scans to augment old fashioned X-rays. And so on up to the genomic revolution of today.

In its first couple of years the NHS comfortably bust its budget with even Bevan declaring that he "shuddered to think of the cascade of medicine pouring down British throats at the moment". Which led to the prescription charge and the first charges for dental treatment - that led in turn to Bevan's resignation.

But if that is the money – and it has kept on growing as medicine has been able to do more - the question is how do you manage it?

Bevan, as already illustrated, is full of great quotes. One of his most prescient, where he was guilty almost of understatement, was that "administration will be the biggest headache for years to come".

And so it has been. The 1948 settlement brought GPs fully into the NHS, with private general practice pretty much disappearing. It nationalised the hospitals. But, for reasons I won't go into, it left considerable parts of health care with local authorities. Public health, the school health service, district nursing, much of maternity and the ambulance service, to name just some of what remained outside the NHS for local government to administer.

Now …. looking back, and given what happened subsequently, it is entirely remarkable that it then took 26 years for the NHS to undergo its first major reorganisation. Not that there weren't attempts along the way so to do that never made it into legislation, ahead of the mighty one of 1974.

Now here I want to attack one of the great NHS myths. That Bevan deliberately created the NHS to be "a Soviet-style command and control system" to quote just one speech by Virginia Bottomley when she was health secretary.

It is a myth that both Conservative and Labour ministers cultivated in later years – most notably from the 1990s on – as a way of contrasting how they intended to manage the service with what went before. It is, in fact, pretty much the opposite of the truth.

I have been lucky enough over the years to interview every health secretary since Sir Keith Joseph in the 1970s, and pretty much unanimously they would tell you that for most of the time they felt they had damn all command at their disposal and remarkably little control. Indeed the story of the 1970s onwards is in large part a search for some levers which, when pulled at the centre, would in fact make a real difference on the ground.

The myth of command and control is based in part on Bevan's own observation that when a bedpan was dropped in Tredegar the sound would echo down the corridors of Whitehall. This is usually quoted as something that Bevan desired. In practice, if you read his speeches around the time of the NHS's foundation, I would maintain that it can equally be seen as something that he recognised would happen, without seeing it as entirely desirable.

Addressing the Royal College of Nursing a month before vesting day he declared that after 5 July, there would be many complaints. The order paper of the House of Commons would be covered in questions. 'Every mistake which you make," he said, "I will bleed for. I shall be going about like St Sebastian, bleeding from a thousand javelins, so many people will be complaining. ' The arrival of the service, he said, would place 'a megaphone' in the hands of those who complained, he said, although he predicted that the number would "dwindle… because you will be attending to them. All I shall be is a central receiver of complaints.' The italics, in there so to speak, the emphasis on the you and the I, are mine. But these hardly sound like the words of a man who saw the echoing of dropped bedpans to be something entirely desirable, or of someone who wanted to run the service by command and control. And certainly he did not set it up that way.

When the NHS was created, GPs operated as independent contractors through local arrangements which were absolutely not arms of the department of health. Indeed, Bevan personally had resisted strong pressure from his own side to make them salaried employees – because he wanted patients to have a choice of doctor, rather than them being allocated to a state employee.

Equally, the hospitals were run by 14 regional hospital boards. Ministers did indeed appoint them. But - yet again- these boards were anything but outposts of the department. It is true that the department issued almost countless circulars – around one every three days in the 1950s. But these, to ministers, chagrin, were honoured at least as often in the breach as the implementation.

In 1950, as the NHS was enjoying the first of its many financial crises, Sir Cyril Jones, a senior civil servant, was appointed to look at its financial workings. But Bevan rejected his recommendations. These included turning the regional hospital boards into purely planning bodies, while the individual hospital management committees beneath them should become – and I quote - 'subject to direct control by the ministry' with civil servants posted out to them in order to ensure that.

Bevan's response was that 'there would have been no theoretical difficulty in having from the outset a tightly administered centralised service - with all that would mean in the way of rigid uniformity, bureaucratic machinery and "red tape". But that was not the policy which we adopted when framing our legislation.

'While we are now – and rightly – tightening up some of the elements of our financial control, we must remember that, in framing the whole service we did deliberately come down in favour of maximum decentralisation to local bodies, a minimum of itemised central approval, and the exercise of financial control through global budgets.'

As Rudolf Klein, the distinguished analyst of the NHS's history has put it, the 1940s and 1950s were characterised 'by a philosophy of administration which saw policy as the product of interaction, rather than the imposition of national plans'.

'The centre," Klein says, "provided the financial framework and advice about desirable objectives. It left the periphery free to work out the details… The centre, quite simply, did not know best – and indeed could not know best.'

Even when it had a clear view about what was desirable, Klein records, 'it did not perceive itself to be in a position to command. It could educate, it could inspire, it could stimulate. To have done more would have run counter to the values of localism… and challenged the right of [clinical] professionals to decide on the content of their work. ' It was 'policy making through exhortation'. Or as one civil servant put it in evidence to a parliamentary committee 'the minister seeks always to act by moral suasion'.

Even Enoch Powell's mighty 1962 Hospital Plan, which promised 90 new hospitals and the remodelling, on various degrees of scale, of some 490 more, became, in Rudolf Klein's words a 'negotiated order'. As civil servants told a parliamentary inquiry, the department could 'advise' the regional hospital boards, it could 'discuss' the plan and seek to 'persuade', but it would not dictate. Not least because – and again I quote - 'it is not easy for us centrally… to form a judgement of the precise needs of each regional board'. The same applied to Powell's other great initiative, the 'setting of the torch to the funeral pyre' of the great Victorian lunatic asylums, announced in his famous 'water towers' speech. It was to take 30 years for the last of them to close.

Indeed at the end of the 1960s, Richard Crossman, Labour's health secretary described the relationship with the service as follows: 'You don't have in the regional hospital boards a number of obedient civil servants carrying out central orders… You have a number of powerful, semi-autonomous boards whose relation to me was much more like the relations of a Persian satrap to a weak Persian emperor. If the emperor tried to enforce his authority too far he lost his throne, or at least lost his resources, or something broke down. '

In time this led to increased frustration as ministers attempted to shape where the money went – putting more into the "Cinderella services" of mental health and care for the elderly for example – while finding that the service too often did respond.

Sir Keith Joseph's mighty 1974 reorganisation of the NHS was, in part, an attempt to answer that. Conceived at the absolute height of British faith in planning, it pulled into the NHS the parts that had been left to local government to administer, and it turned the hospital boards into health authorities with a wider remit for population health planning.

It created regional, area and district authorities, which led, quite literally to arcane disputes about whether there should be a regional porter, or a regional physiotherapist on every regional health authority.

But it created, for the first time, a proper planning system, aimed at indeed bringing a touch more command and control. But, in the days before powerful computers or email, it took the better part of two years, first time round, to get the planning round up and down the system.

In the wonderful phrase of Sir Patrick Nairne, the permanent secretary who inherited all this, the 1974 reorganisation, became a case of "tears about tiers". [Spell it out - Tears about tiers".

The whole thing arrived with a wonderfully meaningless slogan culled from the McKinsey book of management about "maximum delegation downwards, maximum accountability upwards", and it introduced "consensus management". This brought clinicians – chiefly doctors and nurses – on to the boards of the various authorities as of right, alongside administrators, which is what they still were then, not managers, and local councillors - the idea being that the requirement for consensus would be constructive and stop any one element dominating the other.

In practice, that gave everyone a veto. So that where consensus management worked, it worked very well. But far too often it proved to be a recipe for the lowest common denominator decision rather than the highest common factor one, and difficult decisions often got passed up and down the tiers. As Norman Fowler, who in turn inherited much of this put it, 'consensus management became basically a way of avoiding decisions'.

By 1982, the NHS was into its second reorganisation as Patrick Jenkin abolished an entire tier – the area health authorities. But consensus management lived on, even though 1982 was really the start of what might be dubbed "the English NHS disease" – one of "organisation, re-organisation and re-disorganisation" as between 1982 and 2012 the service went through, depending precisely how you count them, more than twenty reorganisations of either its superstructure or the means applied to manage the service. Roughly one every 18 months. I am absolutely not going to list them all.

But the regions moved from 14 to 8 to 4 to back up to 10 – by which time they had become strategic health authorities - before being abolished entirely. Health authorities of various types – including the family practitioner committees - were repeatedly reconfigured and reshaped. At one point 96 health authorities were reduced to 28 before they became the 10 strategic ones. While below them, through several steps, primary care trusts were created whose fledgling numbers at one point totaled more than 450 with that total coming down to around 250 and then 150, before they too were scrapped – PCTs in particular being dug up by their roots so often in the 2000s to see how they were doing that it is a wonder that they did anything at all.

Sir Roy Griffiths, a figure to whom we will return and who I was lucky enough to get to know tolerably well, could be allusive, elusive and occasionally deeply enigmatic. But he was as wise a bird as I have ever met and – at the time we will re-encounter him – was managing director of Sainsbury's at the time when it was indisputably Britain's number one supermarket. And he once said that: "Reorganisation is something that you absolutely should do. But only when everything else has failed!"

So where were the doctors – or more broadly the clincians in all this? Where was the medicine in the management?

To grasp that, one has to go back to what hospitals were like in 1948 just ahead of vesting day. There were more than 1,300 voluntary hospitals and almost 1,800 municipal ones. And they were mainly tiny.

Even the great London teaching hospitals had only around 500 beds and some of them less. The average for the voluntary hospitals was 68, and the tiny cottage hospitals could have 10 or fewer. Most of the municipal hospitals were the old work houses, again often small and serviced chiefly by general practitioners - although during the 1920s and 1930s the big cities and the powerful counties – Middlesex, Birmingham, Bristol, Newcastle, Sheffield and Nottingham for example – had built modern municipal hospitals which attracted academics as well as employing specialists and staff doctors.

In so far as there was a common model for managing them, it usually consisted of a triumvirate.

The medical superintendent, the matron and the hospital secretary. But as the power of medicine grew, and with that its proliferating specialisms, and as Powell's great hospital plan saw the arrival of the district general hospital which in turn led to the steady closure of the smaller institutions, this three card trick struggled to cope with organisations that were steadily getting larger. Medical advisory committees were created. But they tended to be that. Advisory, not managerial.

Over the later 1960s and into the 1970s an arrangement known as Cogwheel was created which, to put it very crudely, sought to create medical divisions within hospitals to involve consultants more in the management of care both inside the hospital and outside it – through their relations with general practitioners.

But the effectiveness of that got lost in the 1974 reorganisation as huge new tiers of cumbersome advisory machinery were created across the tiers before being cut back. Medics – and nurses in large measure, other than in the management of the nursing workforce itself – became detached from management.

And that was the situation in 1983 when Roy Griffiths was whistled up by Norman Fowler and Margaret Thatcher to take a look, initially, at manpower in the NHS.

It is difficult now to recall the febrile state of the NHS back then.

Only six months earlier a report from the Central Policy Review Staff had been leaked which appeared to suggest that Thatcher was intent on dismantling the NHS - even though she instantly disowned it, declaring that the NHS "is safe with us" - while later, during the inquiry, she pointedly choose a private hospital rather than an NHS one for minor eye surgery.

The money was immensely tight and getting tighter – and the service was not in a good place. Beds and wards were closing. Nurses homes were being sold off to raise cash for capital. Cleaning, catering and laundry were forcefully being put out to competitive tender to cut their cost, and manpower targets were being set and enforced, as Ken Clarke, then the minister for health, not yet the secretary of state, was, in his words "clattering about" in a service that "did not have a management system worth its name" - instituting as much command and control as he could muster. Seeking, in essence, to take money out of the non-clinical side of the NHS to keep the clinical side going.

This did not stop the clinical workforce being increasingly detached and resentful in the face of ever tightening resources.

Thatcher, given Griffiths record at Sainsbury's may have thought she had the perfect industrialist to take on the NHS. But Griffiths in fact was deeply committed to it. He had been a Bevin Boy, down the mines, during the war. He had childhood memories of the great depression and of "five bob to go to see the doctor". But his appointment to take a look at the NHS caused outrage. In his own words, "all hell broke loose" as people asked what on earth supermarkets had to do with running the NHS.

He was mocked and indeed booed on public platforms. And when his report came out the Royal College of Nursing ran a quarter million pound advertising campaign asking why nursing was to be taken over by people "who don't know their coccyx's from their humerus".

Griffiths thought he been appointed to deliver a little quiet advice. But he was eventually talked into taking a week off to write "a letter" that was to prove to be one of the most unconventional but crucial documents in the history of the NHS (see Slide 7).

For a start it was just that. Not a report, but a 24 page letter. And it was written backwards. It started with seven pages of recommendations, followed by 13 of diagnosis, and then a brief conclusion. And its recommendations, entirely deliberately, required not a line of legislation.

His report is now chiefly remembered for the famous phrase that "if Florence Nightingale were carrying her lamp through the corridors of the NHS today, she would almost certainly be looking for the people in charge".

Those people, who had disappeared as a result of Joseph's 1974 "consensus management" reorganisation, should be appointed, he said, with general managers replacing administrators, and with consensus management being consigned to the dustbin of history.

Doctors should become involved in running budgets. Treatments should be better evaluated in terms of both cost and clinical effectiveness, with responsibility and budgets devolved to as low a level as possible, while those holding them – the medics - should be held to account. At the centre – and I quote - "a small, strong general management body is necessary - and that is almost all that is necessary at the centre for the management of the NHS. " In other words, an NHS management board or executive should be created – as indeed it was – providing the seed child that in Andrew Lansley's hands, 40 years later, was to become the statutorily independent commissioning board that is now NHS England.

But the Griffiths report is often also mis-remembered.

It became for many years, in the way it was implemented, and with something of a bitter irony, an engine for division between managers and clinicians. Which was pretty much the opposite of what Griffiths intended. His recommendation was that the general managers should come from whatever discipline, including clinicians and most notably doctors. And he was later to say, in all apparent sincerity, that one of his proudest accolades was to be president of the now defunct British Association of Medical Managers.

Since the 1974 reorganisation, the administrators had become appreciably more powerful - and indeed more publicly outspoken - figures. A reflection of the fact that they now ran health authorities, not hospital boards, with a wider remit for population health. And they saw in this "from whatever discipline" recommendation - a real challenge.

People now forget now that, for a short time, they feared it would be the doctors who would become the managers and, most particularly in hospitals, they would be demoted back so to speak, to the hospital secretary role. But the doctors ducked the challenge. Indeed, in the main, they resisted it.

The reasons are many. But they included the fact that, at the time, a fierce debate was going on within the medical profession over "clinical freedom" – a phrase one rarely hears these days. Why?

Well ... the explosion in the power of medicine already referred to had had two consequences. First was a parallel explosion in the medical research literature, and second a remorseless rise in costs as medicine became able to do more.

Take the first of those. In 1988, Sir Miles Irving, who was a professor of surgery at Manchester and much else, pointed out that "When I started medical school in 1954 the Index Medicus (the index of all medical research) was two thin volumes. By 1984 it was 16 fat ones. It now comes four times a year on computer discs each the equivalent of 30 to 40 volumes. It is impossible for any one individual to keep up. " And that was becoming increasingly obvious during the early 1980s, when a whole industry of often not very good – and thus contestable - guidelines to best practice began to be spawned. An industry that led, eventually, to the creation of NICE to put some proper authority around these guidelines.

And to take the second, the rise in costs had created a new interest in cost-effectiveness. As early as 1972 Archie Cochrane, he of what became the Cochrane centre, had published *Effectiveness and Efficiency: Random Reflections on Health Services* which stressed the importance of evidence based medicine – that treatments, in his words, should be based on hard evidence, not just custom, tradition and hunch, and ideally that they should be subject to randomised controlled trials.

"More and more requests for additional facilities," he said, will have to be based not just on "the opinion of senior consultants" but "on detailed argument with 'hard evidence' as to the gain to be expected from the patients' angle, and the cost. Few" - he said with what turned out for many years to be wild optimism – "can possibly object to this. "

And linked to that were the first really serious attempts in the UK in the 1980s to establish the cost of individual treatments, with those figures showing huge, and not easily explained, variations across the country. This was, however, a world-wide phenomenon. Even in the United States, which spent double the amount of the UK on health care, leading physicians at the Harvard School of Public Health were arguing that cost-effectiveness had to be applied. Even the US, they said "will have to think very carefully about how to allocate the resources we are willing to make available".

For many medics this was a deeply uncomfortable challenge. Often brought up to think only of the patient in front of them, many felt their duty was to provide what they perceived to be the best care, regardless of the cost – a stance that reflected the medical profession's long cherished right to individual "clinical freedom".

As Griffiths was reporting, and entirely by coincidence, the cardiologist John Hampton had declared in The Lancet that clinical freedom "is at best a cloak for ignorance and at worst an excuse for quackery. " Clinical freedom, he said then, was "dead and no-one need regret its passing. " But that in itself was causing a mighty stir, and much debate.

Indeed, as one consultant put it to another in a story that Griffiths himself related: "Your demand for resources, whatever the cost, is in fact the denial of my resources."

So Griffiths calls for cost-effectiveness to be applied, and for doctors to take direct responsibility for their budgets – and indeed become general managers – were launched into turbulent waters.

As Duncan Nichol, once chief executive of the NHS, put it on the NHS's 60th anniversary, "it could have been theirs" – the general management role for medics.

"If you have an MBA in the States," he noted, "and you're a doctor, people think you are a pretty sharp guy. Here they think you are a grubby businessman. A bit of a quisling. Someone who has gone over to the dark side. And it is beneath you. " As a result, he says, and at the time we are talking about – the mid-1980s - "the medical profession in this country kind of abdicated its role to managers, and then bitched about the result and disengaged."

Thus it was that, in those early days, pretty much the only medic who became a general manager was the wonderful Sir Cyril Chantler, a paediatric consultant, who became general manager of Guys. There, he introduced medical managers for each division within the hospital. A model that – painfully slowly – has now been adopted in one form or another pretty much everywhere. But it has been a way over long process.

All that said, the Griffiths report – and I am not the only one to hold this view – was one of the absolutely critical NHS documents. It quite literally rescued the NHS from a parlous state. It got rid of the failure of consensus management. It provided, through the management executive, the makings of a lever which when pulled at the centre could indeed produce some results on the ground.

And without it – without its creation of general management – the dramatic reforms of 1991, Kenneth Clarke's introduction of the original purchaser/provider split into the NHS, would not have happened. There would have been no-one to deliver it, because it was managers who pushed through the applications to become more free-standing NHS Trusts, in at least a few places in the teeth of direct opposition from their consultant bodies.

And, it has finally turned out - over too long a period – that Griffith's strictures, and those of many others, played through. That cost-effectiveness analysis be applied, and that the involvement of medics in management was critical to the success of the service. But it was pretty much a 30 year war.

Now … Time, alas, is limited. And I am sure – well I hope – that you don't want just to listen to a lecture from me. I'd like time for some debate and questions.

So I am going to massively truncate the next chunk of history, other than to note what went with the 1991 reforms with their creation of the purchaser/provider split, which involved GP fundholders and health authorities commissioning care from competing, and nominally more self-standing and independent, NHS Trusts.

In a sense, for the first time, the NHS was to take a conscious decision about what it wanted to supply to its patients and then buy it from whoever looked best to provide it – the private sector, the voluntary sector or NHS Trusts who would have to compete for the business. And we can debate how effective that has been.

In the course of that the NHS Management Board as it started out, went through a bewildering series of incarnations finally to become, in 2013, the statutorily independent NHS England.

But there is a neat paradox in here. This more market-like approach – always a quasi-market, nothing like a real one - and Labour's re-invention of it in a more sophisticated form in the 2000s, was ultimately aimed - in Patricia Hewitt's words when health secretary in the mid-2000s - at producing a "self-improving" NHS.

One that would require less ministerial and management action from the centre as the quasi-market forces of commissioning and supply took effect. The paradox here is that, following Griffiths, and over the 1990s and into the 2000s, something closer to the command and control of which the NHS had long been accused also took effect.

There was more of a line management arrangement than in the days before Griffiths. One which probably reached its peak in Frank Dobson's day when virtually all the new money for the NHS was specifically earmarked for ministerially determined initiatives.

Although I suspect if you asked Alan Langlands, Nigel Crisp or David Nicholson, successive NHS chief executives, whether they felt they had a lot of control, leave alone command, their response would be "some, but not much".

And – another paradox, although more of an irony – is that with these more market-like mechanisms came a huge rise in regulation, with an NHS inspectorate and then Monitor to oversee the nominally free-standing NHS Foundation Trusts that Labour created. Which produced its own reinforcement of command and control – or at least less freedom of action at the front-line than there might have been.

The rise in regulation and inspection happened across public services, not just in the NHS. The reason being that when services were more directly administered, or even directly managed, either by central or local government, ministers could suffer from the delusion that they or their civil servants knew what was going on out there.

Once things were run more at arms-length, both they and the public needed regulators and inspectors to tell them what was happening. So in education you get Ofsted. In higher education you get Hefce and the other regulators, in social care a new inspectorate, now part of the CQC, along with new housing inspectorates, and so on. To the point where Britain has long had more public service inspectors than it has taxi-drivers. At least until the arrival of Uber.

With the Lansley reforms, of course, faith in the market mechanism reached its apogee with Lansley creating what Sir David Nicholson, the NHS chief executive, dubbed "a clockwork universe" or what one of Cameron's despairing special advisers described as "a perfectly incentivised perpetual motion machine", there to deliver the "self-improving" NHS that Labour desired.

Clinicians came back into the picture with all GPs meant to be involved in commissioning, while all hospitals – yet again – were meant to become foundation trusts, with any willing provider allowed to supply NHS services and with Monitor becoming a pro-competition market regulator, with provider organisations expected to respond to the various incentives and penalties that went with all that.

In practice, something rather different has happened. Competition has more or less dropped out of the NHS political lexicon. As Simon Stevens, the boss of NHS England, has put it, where accountable care organisations or systems are created that will "effectively mean the end of the purchaser/provider split".

But that's a whole other issue, affected in part by the money – running a quasi-competitive market does not work when real resources are close to shrinking and you cannot, in practice, simply close a big hospital because it is financially bust. And accountable care organisations, or anything like them, also redefine the management challenge. How do you hold them to account?

So what of the medicine, or the management of medicine?

Well, we have, I will concede, come a long way from the dog days of the 1980s when medicine and management were a stand-off. Clinical directors and medical directors are now common place.

But too often these posts still feel a little like "Buggin's turn" rather than a wholesale commitment to them. And there are now clinicians – though more nurses than doctors – who have become hospital chief executives. But I have grown a little weary over the years of hearing clinicians moan about management while doing little or nothing – at least until more recent times – to take responsibility for it.

For it is genuinely notable that if you look at the chief executives or equivalents in many of the best US and European hospitals they are clinically qualified and many of them are medics.

So, while things have got better – much better – it remains my contention that one of the NHS's most persistent weaknesses has been the failure fully to engage medics in management, and the failure of medics themselves fully to engage with it.

I should stress here that I have nothing against managers. Some of my best friends, as they say. And the NHS cannot run well without first class management. But still greater clinical engagement in the management of the service would, in my view, be a good and productive thing.

Medics will take from medics things they will not take from managers. Anecdotes are not evidence. But let me illustrate that with just one story.

When Cyril Chantler took over Guys they were overspent. One piece of analysis showed that Guys had far more phlebotomists than comparable hospitals. So they decided to reduce the numbers, producing instant protests from the doctors. But at the big board meeting to decide that, with the clinical directors all present, Cyril was able to point out that as a renal paediatrician he took all his own bloods as part of the consultation. "One reason I do," he said, "is that I can tell the child that this is going to hurt, but only a little bit. And that is confidence and trust building. So when I tell them something won't hurt, or will hurt quite a lot, they believe me. If I can do it, why can't you?" Collapse of stout parties, as they say. But can you imagine that conversation if it was a manager who was leading it?

One of my reasons for optimism is that the publication of more data about unit and consultant performance has started to harness a different form of competition to the financial competition of the quasi-market – namely peer pressure among consultants not to be unreasonable outliers in terms of both clinical care and cost-effectiveness. The most spectacular example of that was cardiac surgery, where, by publishing their results to each other cardiac surgeons moved themselves from a relatively mediocre performance to the best results in Europe. But there are other examples.

And the new Getting It Right First Time programme – in which clinicians in all specialities are presented, not by managers but by leading clinicians – with all the available data about their practice, from the money they spend, to the results they get, to their litigation rate and how they compare to their peers does seem to have real potential to engage clinicians more in the practical and financial management of their work.

So I am not in despair. But if the triangle of money, medicine and management had been in better balance over the years – the growth money being more consistent rather yo-yo-ing, and the medicine and management better engaged with each other – the NHS would be, and could yet be, in a better place.

And that is pretty much it. I will do my best to field any questions or counter-arguments!

And, while I do, slides of a number of publications that address some of this will rotate behind me. All of them, I confess, I've had a hand in. But most of what is in them are other people's words rather than mine. Most are free downloads, and most provide either more detail or more background, than has been possible tonight.

Professor Nicholas Timmins