Localism, Fairness and Empowerment in the NHS

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Applicability

With the devolution of powers to Scotland and Wales, many decisions made in Westminster now apply to England only. That means that policies in those nations are increasingly different from those in England – reflecting different choices, priorities and circumstances, and often the influence of Liberal Democrats in government. This document sets out proposals for what a Liberal Democrat government in Westminster could achieve.

Some policy proposals published by the Liberal Democrats may imply modifications to existing government public expenditure priorities. The Liberal Democrats recognise that it may not be possible to achieve all these proposals in the lifetime of one Parliament. The Liberal Democrats intend to publish a costings programme, setting out our priorities across all policy areas, closer to the next general election.

CONTENTS

INTRODUCTION

Liberal Democrats have always had a strong, unswerving commitment to the National Health Service. Created in 1948, the NHS had its origins in the Social Insurance and Allied Services Report written six years earlier by William Beveridge, a Liberal, who later became leader of the party in the House of Lords.

Since its inception, the NHS has become part of what defines this country. Nigel Lawson once described it as the 'national religion'. Despite the enormous challenges it has faced over the last half century, the NHS is still very strongly supported by the public. Any government which fails to exercise effective stewardship of the NHS pays a heavy political price.

The remarkable situation we have today is that despite record investment in the NHS, doctors and nurses and other health professionals have lost confidence in the Government, especially in relation to the reforms in England. Opinion polling shows a similar loss of trust amongst members of the public.[i]

If we are to sustain the NHS into the future, we have to ensure that it performs effectively and that it meets the needs of today's patients. It has to be capable of adapting to new challenges presented by medical science and the rising expectations of patients**.**

The National Health Service is the world's fourth largest employer after the Chinese Army, Indian Railways and Wal-Mart. It employs over 1.33 million employees. This Labour Government has sought to manage this vast organisation with a remarkable degree of central control. In all my discussions with professional people working in the National Health Service there seems to be a broad and growing consensus that this 'command and control' approach is, ultimately, unsustainable. In a frank assessment of the state of the NHS at the end of her tenure, Patricia Hewitt admitted that the 'NHS is four times the size of the Cuban economy and more centralised'.

Despite this central control and despite a strongly stated commitment from the Government to the principle of equity, we have, nonetheless, significant variations in terms of access to treatment across the country but without any accountability to local communities in respect of access decisions.

We have also experienced growing health inequalities between the wealthiest and the poorest members of society. Liberal Democrats find this totally unacceptable. These inequalities are caused by social and economic factors that have little to do with the NHS, but weaknesses in the health service tend to have a disproportionate effect on the most disadvantaged communities.

FUNDING THE NHS

The NHS has always been primarily funded through general taxation. In 2001, Derek Wanless was asked by the Government to consider the sources and scale of funding of the NHS. His conclusion was that general taxation was the most cost effective means of funding – and the fairest - but that it would have to be at a higher level to meet the challenges ahead. Liberal Democrats supported those conclusions.

The NHS had suffered many years of chronic under-investment. In 1997, as the Conservatives left office, the UK spent 6.8% of GDP on health (public and private provision) compared with 9.1% for the rest of the EU. The cumulative impact of this neglect was there for all to see – and suffer. People often waited, in pain, for years for operations. There was a serious shortage of doctors, nurses and other health professionals. Not enough were being trained. The state of hospital buildings was a disgrace. Critically, health outcomes were poor compared to other countries with similar levels of income per head of population.[ii] The Conservatives had been guilty of almost criminal neglect. Depressingly, nothing really changed during the early years of the Labour Government.

So the Liberal Democrats were at the forefront of arguing the case for boosting investment in the NHS. And we supported the Government when it finally committed to raising the percentage share of GDP spent on health to the European average.

Now, spending on health stands at 9.2% of GDP. The UK has one of the highest levels of public spending on health in Europe but one of the lowest levels of private expenditure. The result is that overall, we are somewhere around the European average for overall spending although the legacy of historic under-funding is bound to have some lasting effect.

The Government has made it clear that this is the last year of significant growth in funding and so we do not expect the share of GDP spent on healthcare to continue rising.

Despite this dramatic increase over the last few years, we have witnessed the remarkable situation of large numbers of primary care trusts and hospital trusts suffering significant deficits. Even after a year of cutbacks, (and despite the fact that the NHS as a whole got back into surplus) the cumulative deficit of those trusts in deficit at the end of 2006/07 was approaching £1 billion. No-one ever imagined that this would be the position when the extra resources started to flow. NHS accounting rules have also conspired to make it very difficult for trusts to recover once they get into deficit.

So the issue now is much more about how the money is spent rather than a debate about the need for more resources. That may change in the years ahead given the pressures of an aging population and rising cost pressures but at present the challenge is to use the available funding more efficiently so that better outcomes can be achieved. We should also never be complacent about the importance of *maintaining* adequate levels of funding.

LABOUR'S STEWARDSHIP OF THE NHS

First, it is fair to say that progress has been made since the dark days of the 1990s. Waiting lists have come down significantly. Cancer survival rates have improved. New hospitals and health centres have been built and the NHS now employs thousands more doctors, nurses and other health professionals. The Government was also right to establish the National Institute for Health and Clinical Excellence (NICE) to provide an independent assessment on the use of medicines, treatments and procedures within the NHS. National screening programmes have also been a positive development.

However, so much more could have been achieved. Labour's record, overall, can be characterised as inconsistent, confused and incompetent.

Before taking office, the Labour Party promised to abolish the internal market. Instead it has extended it. Labour created primary care groups, then abolished local health authorities and established 303 primary care trusts. Just 3 years later many of these were abolished with the total number reduced to 152. Each change leads to a loss of morale amongst staff, enormous redundancy and early retirement costs, and another destabilisation of the service. It also abolished Community Health Councils and established Patient and Public Involvement Forums. But they only lasted three years before yet more legislation proposed their abolition and replacement with LINks (Local Involvement Networks).

The private finance initiative (PFI) has been used to fund a substantial building investment programme – with no capital planning or budgeting of the on-going costs. £18 billion has been committed to PFI schemes up to 2014/15. The use of PFI has resulted in the creation of a straight-jacket of expensive, serviced accommodation for perhaps 30 years into the future at the very time when the Government tells us – rightly – that we have to be able to adapt the delivery of our health services to new demands.

It should also be noted that we have witnessed a massive missed opportunity - with such a substantial public building programme – to take the lead on achieving low energy facilities. PFI schemes have paid lip-service to high environmental standards.

The NHS has also been left to pay the price for the central imposition of a grandiose IT system – now running behind schedule and billions of pounds over the original budget.[iii]

The Government has also demonstrated incompetence in the way in which it has negotiated 'Agenda for Change' and contracts with GPs and consultants, with costs again running hundreds of millions of pounds over budget.

The new NHS dentists' contract was introduced without proper piloting and has failed in the stated objective of improving access to NHS dentistry. The Government badly miscalculated the level of income from patient charges under the new system, resulting in primary care trusts across the country exceeding their budgets.

Then came the junior doctors' recruitment fiasco. A new centralised computer system – MTAS - introduced without proper piloting, caused chaos. Junior doctors were left totally disillusioned after years of study. We stand to lose many of our best doctors to other countries' healthcare systems as a result. Nurses have also been demoralised this year by their staged pay increase.

The Government has also failed to get to grips with the challenges of an aging population. The organisational divide between health and social care has made the delivery of integrated services much more challenging. Cost pressures have resulted in the shunting of responsibility between the NHS and social services authorities often to the detriment of the patient.

The common thread running through a lot of what has gone wrong is the fact that so much is directed from Whitehall. The centre thinks it knows best and all too frequently fails to listen when concerns are raised. However, when things go wrong, they go spectacularly wrong because the same wrong solution has been imposed across the whole country.

The rhetoric has been very different. The Government talks of local decision making but, in truth, too much of the power is in Whitehall.

The Government has now embarked on an exercise of listening to staff and patients in order to help shape future direction. The whole thing smacks of an admission of failure after 10 years floundering around trying to find a strategic direction. However, there is evidence that morale amongst staff is very low. It is remarkable that this is the case given the overwhelming support across the service for the Government's NHS plan published just five years ago. A top priority has to be to rebuild trust and to get professional and support staff re-engaged.

THE WAY FORWARD

What then are the principles which should guide Liberal Democrats in developing the right way forward for the NHS? I have identified four key areas.

GUIDING PRINCIPLES

- **Equity and Fairness**.

Every citizen matters. Our NHS must deliver high quality health services to all, irrespective of income. It must function on the basis of fairness. We cannot tolerate second rate services. The most disadvantaged citizens must not be excluded from high quality health care. But we recognise that the priorities in one geographical area may be different to those in another.

- **Local Democratic Accountability and Devolved Decision-making.**

It is extraordinary that local communities have no effective say in how their health services are run. Primary Care Trusts, which are responsible for commissioning – or buying - health services, are accountable to Strategic Health Authorities, which, in turn, are accountable to the Secretary of State. This has to change.

- **Empowering Patients**.

Liberal Democrats believe fundamentally in giving power to citizens to take control of their lives. This is as important in terms of health care as in any other sphere of life. We cannot any longer justify a view of patients as passive recipients of care. Instinctively, we have a particular concern for those without power, those who are most vulnerable. The challenge is to ensure that everyone is valued, that everyone plays an active role in the decisions relating to their care. Citizens should also know what entitlements they have from the NHS and should also be aware of their responsibilities.

- **Efficient Use of Public Resources in Delivering High Quality Services**

In delivering high quality health services it is incumbent on government to ensure the best achievable outcomes for patients, but also the most efficient use of tax payer's money.

In applying all of these principles, it is important to reassert the case for engaging clinicians in the decision-making process at all levels. Clinicians have to be seen as key to improving care, rather than as barriers to it.

EQUITY

It is a totally unacceptable failure of public policy that we have actually experienced growing health inequalities in this country and this has continued under Labour.[iv] This must be challenged. The impact of these inequalities is stark. There are significant differences in life expectancy between better off communities and the most disadvantaged. For example, in East Dorset, the life expectancy for men is just over 80 years, but in Manchester it is less than 72 years.[v] The gap in *healthy* life expectancy is even larger (17 years).[vi]

Infant deaths are far more prevalent in poorer communities. There are just 2.9 infant deaths per thousand live births amongst the most affluent groups compared to 8.9 deaths at the bottom end of the income scale – including those who are unemployed.[vii]

Access to services is also unequal. In 2004 there were 62.5 GPs per 100,000 of the population in the least deprived PCT areas compared with only 54.2 in the most impoverished, despite the fact that in these areas people have worse health. And there is a direct link between access to services and health outcomes. Ethnic minority communities may also suffer worse access to health services. The Kings Fund reports that the Department of Health's own surveys show lower levels of satisfaction amongst some ethnic minority communities. Those responding to one survey from Pakistani, Indian and Bangladeshi backgrounds reported significantly poorer experiences (as hospital inpatients) than White British or Irish respondents, particularly on questions of prompt access, as well as their experience of involvement and choice.[viii]

The influences of health inequalities of course go well beyond the scope of the NHS. However, the health system plays an important part. Policies relating to the NHS and its work with other Government departments can contribute to either worsening or reducing health inequalities.

FROM INCAPACITY BENEFIT TO WORK

One area which deserves particular attention is the question of how to help those on incapacity benefit back to work. The Department of Health and the Department of Work and Pensions have failed to work effectively together in this regard. Lord Layard, in his 'Depression Report'[ix] published in 2006, highlighted the extraordinary waste of human talent as a result of so many people with mental health problems stuck on incapacity benefits – people who could be successfully treated but who do not get access to psychological therapies. One million people are on incapacity benefits as a result of mental illness – more than the total number of people

receiving unemployment benefit. 30% of new applicants for incapacity benefit have a mental illness.

The cost to the economy is equally significant. Lord Layard estimates that the total loss of output due to depression and chronic anxiety is some £12 billion a year – 1% of national income. Yet, despite this, people are not getting the help that they need. NICE has issued guidelines stating that psychological therapies should be available to all those with depression or anxiety disorders or schizophrenia, unless the problem is very mild or recent. But the guidelines cannot be implemented because there are not enough therapists. Only one in four people suffering from depression or chronic anxiety is receiving any kind of treatment.

So whilst the economy is losing billions in lost output and the tax-payer is funding benefit payments, the Department of Health is failing to invest in training sufficient therapists to comply with NICE guidelines which would help people back to work. We must break this ludicrous silo approach to Government. (There is also a compelling case for improving access to treatment for those not of working age given the potential for improving quality of life.)

The same goes for investment in physiotherapists and other allied health professions. 500,000 people on incapacity benefit have muscular/skeletal injuries. International research shows that early intervention produces excellent results and helps get people back to work.[x] Yet access is very patchy. Investment by the Department of Health could help many escape from poverty and secure substantial savings for the Department of Work and Pensions – yet there is a failure to work effectively together. Meanwhile, The Chartered Society of Physiotherapy reported in July this year that of the 2413 students graduating in 2006, 63% were still without their first permanent NHS junior physiotherapy post.[xi]

Liberal Democrats should commit to this cost-effective investment in physiotherapy services. I would also like to investigate mechanisms to encourage better joint working between Government departments. This could include the NHS receiving a payment from the Department of Work and Pensions if, through access to, for example, physiotherapy services or psychological therapies, an individual is helped back to work. Employment support providers could also have the right to commission these services outside the NHS if the individual was experiencing unacceptable delays.

PUBLIC HEALTH

We will also be developing proposals to focus attention on the big public health challenges, such as obesity, alcohol consumption and smoking with the aim of securing the key Liberal Democrat commitment of reducing health inequalities.

Nationally, the Secretary of State for Health must have a clear responsibility for public health. But effective implementation of public health initiatives depends on local engagement. The Director of Public Health should always be a joint appointment between the NHS and local government. Health promotion and prevention must be fully integrated into local community plans. Directors of Public Health are then in a position to lead positive action in a number of areas including:

- Strategies that empower people to improve their lives;
- Community development to increase the capacity of local communities to resolve their own problems;
- Community initiatives which identify and address health challenges;
- Engagement with schools to ensure that health promotion is incorporated into the curriculum;
- Integrated transport policies that support increased physical activity and improve access to health care services;
- Regeneration initiatives that address deprivation and that measure impact on health;
- Use of development control powers to improve environments, including in housing and which promote sustainability.

ACCESS TO MEDICINES

There are persistent claims that the UK compares unfavourably with many other European countries in terms of access to and uptake of newly licensed drugs under the NHS and that this slow uptake persists even after approval by NICE. If this is the case, the fear is that the most disadvantaged may lose out most. There should be a thorough analysis to establish the facts and to identify the causes of any weaknesses in the UK.

LOCAL DEMOCRATIC ACCOUNTABILITY

At present, primary care trusts boards are appointed by the national NHS Appointments Commission. Few people have any idea who is on the board of their local primary care trust. They are accountable to strategic health authorities (SHA), not to local people. The SHA board is also appointed centrally. The line of authority and accountability runs straight up to the Secretary of State.

The only democratic local voice within the system is provided through a range of interactions with the local authority including:

- Scrutiny by the Overview and Scrutiny Committee of the local authority (generally, the County Council or the Unitary Authority). These committees – which in some areas are asserting themselves impressively, but in others, are conspicuous by their ineffectiveness - have the right to investigate major proposals for changes to service provision. However, if they decide to object to such proposals, their appeal is to the Secretary of State, who refers the case on to an independent review panel. The Secretary of State, inevitably, has the right to veto such a referral. Until recently, the veto has been regularly used and the original proposals of the primary care trust upheld – overruling the one local democratic input into planned changes to service provision. Total central control. Now, following a lot of pressure, the Secretary of State has agreed to refer all cases to the independent panel, but that is still at his discretion;

- Joint staffing appointments in areas such as children's and third age social services and public health with almost all public health appointments being made and paid for jointly;

- Joint setting of priorities through Local Strategic Partnerships and Local Area Agreement structures;

- Merging of budgets through a wide range of joint projects and programmes.

But for Liberal Democrats, including the party's councillors, this is not enough. Overbearing control from the centre has to be challenged. It creates a dependency culture. Local people have no effective say over their health services - no power to determine their own destiny. No control, no responsibility, no accountability. Local managers, health professionals and citizens are not encouraged to take responsibility for tough priority decisions that may need to be taken because they can blame the Government. If we do not like what is happening in our local health services, all we can do is complain to the Government. And it does not listen.

Local authorities currently have no local mandate for health initiatives. They approach the subject tangentially through their wider powers of environmental health, environment, sport, leisure and so on.

The answer is to create local democratic accountability and a genuine devolution of decision-making so as to reflect local priorities. There are a number of ways in which this could be achieved. My preference is to do this without yet another change of structure – which would simply destabilise health professionals who have suffered too many changes of employer in recent years.

My proposal is to focus on the body responsible for commissioning of health services – the primary care trust. This is where local people should have a say – over what health services are secured for local people and in ensuring that we get value for money from providers. Until very recently, the importance of commissioning has been badly neglected, with the Government focusing all its attention on providers.

Many people have no real idea what a 'primary care trust' does. The title is meaningless – and actually inaccurate in terms of its core function. They should be renamed 'Local Health Board'.

There are two options for achieving local democratic accountability. Ultimately, there is no reason why the same model has to apply across the whole country. This could be determined by local people.

The first option, which involves no change of structure, is that instead of the Health Board having its board appointed nationally, there could be a directly elected board. The number of elected members should be relatively low. They should be in a majority on the board, supported by appointees who would provide financial acumen and health expertise.

Alternatively, the work of the PCT could be transferred to a local authority (almost all PCTs are now co-terminous with upper tier or unitary authorities). Democratic accountability is thereby secured through the normal council election process. There are various models for local authority led health care commissioning:

- The local authority could nominate the majority of board members of a stand alone Health Board;

- The same arrangement as above but with significant levels of joint working between health and social care;

- The Primary Care Trust/Health Board becoming entirely integrated with the council.

Different models may fit different circumstances. It could be for local people to decide. Any change under which Health Board powers passed to a local authority would only take place if local people indicated their support in a local referendum.

HEALTH AND SOCIAL CARE

Whichever route is taken, our aim should be to bring health and social care together. This would end the structural divide between health and social care. I believe there is a powerful case for this as the ultimate objective. In Northern Ireland, there is no divide between health and social care. One cannot make direct comparisons. The current structure in Northern Ireland is for four Health and Social Care Boards to act as commissioners and for Health and Social Care Trusts to act as providers of both acute and community services. It should also be noted that in November, 2005, the then Minister for Health in Northern Ireland proposed the establishment of a Health and Social Services Authority in place of the four Boards. No final decision has been taken.

From the patient's perspective, the need is for a seamless service. In some areas in England there are good working arrangements between the NHS and social services. For example, exciting developments are taking place in Herefordshire with the creation of the Health and Social Care Compact. This involves the Herefordshire PCT, the County Council's Adult and Children's services directorates and the voluntary sector signing up to 'shared principles and commitments to action'. But this sort of collaborative working is still the exception rather than the rule. Too often costs are shunted from one organisation to the other. Judgements are sometimes made on the basis of budgetary considerations rather than what is in the best interests of the patient.

There are also potential savings to be made from bringing health and social care together into one board with one administrative hierarchy rather than two. And there is the potential to have one IT system for health and social care. The National Programme for IT has largely ignored social care and yet, in terms of service delivery, it seems crazy to have separate systems for health and for social care. There are important governance issues to resolve but the principle is clear. The organisation, Intellect, the trade association for the UK hi-tech industry, argues that 'one of the most significant issues in improving whole care processes in England is the incomplete integration of service across health and social care'.[xii]

It would make sense to trial the creation of a health and social care board in order to empirically assess its effectiveness.

Whatever the timescale for any move towards greatly enhanced integrated health and social care services, there must surely, at the very least, be a statutory duty on

both Health Boards and Social Services Authorities to develop and commission joint services and to establish joint budgets.

I would welcome a debate on how best to integrate health and social care. There should be the potential for different options applying in different parts of the country but all working to agreed principles and standards of local governance.

TAX-RAISING POWERS

But true democratic accountability can only be achieved if there is some power to raise funds locally. The UK is the most centralised of all Western democracies – with the exception of Malta - in terms of where taxes are levied. 95% of taxes are raised centrally in the UK compared to an EU average of just under 60%. Power resides where the money is raised. This stranglehold has to be broken. My vision is of far more accountability - and responsibility - on the part of those actually in charge of commissioning local health services.

We envisage further decentralisation of tax-raising powers, as laid out in Liberal Democrat Policy Paper, "Lifting the Burden" and a further replacement revenue source would be the equivalent of local income tax – which could be clearly defined as a 'local health contribution'. The bulk of the funding would still come from national government which ensures that equitable distribution can be maintained – nowhere would lose out because of a low tax base or because of the level of health needs.

Once this decentralised framework was established, either the local health board, or the local authority –where that body had taken on the commissioning of health services - would have the power to vary the rate of 'local health contribution'. But they would be accountable for the way they spend that money. To provide reassurance, increases in the 'local health contribution' would be capped with the power of local democracy imposing financial discipline.

STATUTORY DUTY: VALUE FOR MONEY, EQUITY AND QUALITY

If established, Health Boards should be subject to the same statutory duty to achieve best value for money that already applies to councils... In exercising their functions they must have regard to equity and to quality. They should be open to contracting with a diversity of providers. The key should be that all providers must meet exacting standards of care - set nationally - whether they are in the public, voluntary or independent sectors. There must be a financial level playing field, in place of the favoured treatment that centrally imposed, Independent Sector Treatment Centres currently enjoy. They should be subject to the same rules of openness and access to information. There should be an end to the central

imposition of Independent Sector Treatment Centres. Engagement with the independent and voluntary sectors should be a matter for local decision-making.

PUBLIC BENEFIT ORGANISATIONS

The Huhne Commission[xiii] considered the role that could be played by what it called 'Public Benefit Organisations'. I strongly favour developing the potential of this sort of social enterprise. In my North Norfolk constituency, the small cottage hospital in Wells-next-the-Sea used to be run by the Primary Care Trust. It was neglected and ultimately faced closure. A group of dynamic local people then intervened and established a charitable trust which took over the hospital. Now it has a real local focus. It runs a wide range of clinics with specialists coming out to the hospital from Kings Lynn and Norwich. It serves NHS patients just as it did before. But there is a strong local commitment to secure the hospital's future and substantial sums are raised by the town for the benefit of their hospital. This is typical of many cottage hospitals around the country with 'Friends' groups raising vital funds for local health care. Many of them started life as 'Memorial Hospitals' serving their local town. The Wells initiative – along with others elsewhere - offers an exciting model which may well have wider application. I would like to see steps taken to facilitate the development of such social enterprises.

It is, of course, essential that any voluntary sector organisation contracting with the NHS, must demonstrate robust finances and sound clinical and corporate governance arrangements.

AUDIT OF LOCAL HEALTH BOARDS

If established, Health Boards should also be subject to audit by a national standards body, such as the Audit Commission, just as with local government. In respect of clinical matters they would continue to be subject to scrutiny by the Healthcare Commission. Local people need to have the information upon which to measure, objectively, the performance of their local health board.

REFORM OF PAYMENT BY RESULTS

Local decision-makers should also have the right to vary the national tariff under 'payment by results'. This confusingly named system - which provides for money following the patient - is still in its infancy. It has the potential to reward efficiency and it does introduce a more transparent rules based system by paying trusts for the work they do. However, it has limitations. There are a number of provisos to its application:

- There is a limit to the type of procedures and treatments which are susceptible to this sort of menu pricing. For example, for chronic, long term conditions such as diabetes, it may make more sense to negotiate the cost of a total care package for the year so that hospitals are not simply paid for each admission. This could facilitate more effective joint working between primary and secondary care;

- Generally, we need to explore ways of developing payment by results to introduce improved incentives for acute hospitals to co-operate with primary care to help keep patients out of hospital. The danger with payment by results is that the incentive is simply to treat as many patients as possible – as quickly as possible;

- More work needs to be done to develop the idea of unbundling tariffs – breaking them down into their constituent parts – so as to ensure that financial incentives provide for diagnosis and care in the most appropriate setting;

- In a decentralised system, there should not be an inflexible national tariff. Although the tariff is adjusted by a system called the 'market forces factor', it is crude and inaccurate. The local Health Board should be able to negotiate adjustments to the tariff with local providers. This is entirely appropriate given their role as commissioners of health care and given my proposal for a duty to apply to Health Boards to secure value for money. (This need not constrain the right of a patient to choose to go to a hospital in another area.).

CAPITAL PROJECTS

Decisions about capital projects would be the responsibility of local decision-makers. They could decide whether or not to use PFI for capital projects. They could alternatively issue Health Bonds to raise funds for capital projects. This could be subject of local referenda. In the USA, decisions of this sort are put to local communities by way of a 'proposition' on the ballot paper at election time. The community would be asked whether they approved the issuing of a Health Bond to raise funds for a particular capital project such as the building of a new hospital or health centre. Bonds would be secured against assets.

Where PFI is used there must be much more transparency about the financial package. There is no reason why these deals should escape full scrutiny. Those entering new PFI deals should also ensure that there is much more flexibility built into the contract in respect of support services – allowing the capacity to adapt those services to changing circumstances.

There should also be the option of traditional NHS capital funding methods of financing projects.

STRATEGIC PLANNING AND TERTIARY SERVICES

With decentralised power and accountability, it would no longer be appropriate to retain Strategic Health Authorities in their current form. These Authorities effectively represent the Secretary of State in each region. They operate in the shadows.

In place of the Strategic Health Authorities there would still need to be effective planning of tertiary services – specialist units which cannot be provided in every Health Board area – across a region. A body with representation from local health boards could exercise this function and have a role in staff training and workforce planning. Health boards should also secure commitments from independent and voluntary sector providers to play their part in training of healthcare professionals.

These bodies could co-ordinate a regional approach to public health. They should also play a role in education and training, working to align research and education networks with clinical networks. And they should develop workforce planning. The National NHS Commissioning and Advisory Authority (which I envisage as one option) would work with Health Boards to establish these bodies.

EMPOWERING THE PATIENT

For Liberal Democrats, empowerment is central to our vision of society. It is just as important in healthcare as in any other sphere of life. But what should this amount to in terms of what the NHS offers to patients? How should we respond to the Labour Government's 'choice' agenda? What are the risks of introducing greater choice? Does it lead to greater health inequalities?

CHOICE AND EQUITY

The Labour Government has claimed to champion 'choice'.

However, concerns are often expressed that the introduction of choice will have the effect of increasing health inequalities. The claim is that the articulate middle classes will take advantage of the opportunities available whereas everyone else will be left with second rate services. It is tempting to conclude that this should lead us to a rejection of choice.

This would, however, be a mistake. First of all, there is no doubt that if you offer no formal choice, those who know how to 'play the system' can still gain an advantage. Disadvantaged groups are left with less choice and poorer health.

Nonetheless, there is no doubt that the introduction of choice without adequately focusing on how disadvantaged groups (whether as a result of poverty, age or infirmity) can really take advantage of it risks making things worse. Untrammelled competition without an effective local commissioning body can have the perverse effect of reducing choice (as a result of services closing down) and of creating sink services for patients less able or willing to travel.

But choice does not have to lead to greater inequality of health. Our starting point is that all citizens should be empowered to make the best decisions for their own health. Public policy should have a central objective of ensuring that that becomes a reality. Choice and empowerment can then have a real impact on reducing inequalities of access to services and therefore reducing inequalities of health outcomes.

In the London Patient Choice Project, patients were given the option of free transport. They were also supported in making decisions about which hospital to choose. Patient Choice Advisers performed this role. The outcome of the pilot was that there were no negative impacts in terms of inequalities in accessing services. Disadvantaged groups were empowered to make rational choices about which hospital to choose.

However, when the 'choice agenda' was rolled out nationally, no provision was made for supporting access to services or for guiding patients in exercising choice. An ippr study concluded that in these circumstances, 'choice is likely to increase inequity'.[xiv]

INFORMATION

Reliable information is, of course, essential in order to make rational decisions about access to services. It is also important in terms of achieving better accountability and in improving quality of care.

There are, broadly, two types of information about health and healthcare that are increasingly available to the public. First of all, there is information about diseases and remedies. Secondly there is information about the quality and efficiency of health services. Within this second category, far more information is available now about the performance of hospitals and other health services. The Healthcare Commission website allows you to find out all sorts of information about the performance of your local hospital. We should positively welcome this trend, whilst recognising the very real limitations of the information currently provided.

The Government has recently launched a new website called 'NHS Choices' which is the latest attempt to improve the type of information available. However, it has been criticised for being inaccurate.

The way that information is provided is also very important. It should help the patient make judgements about specific elements of care. Comparisons on performance should be made with the norms of acceptable levels of performance, rather than attempting to create league tables of providers.

Access to information must also be extended to private sector providers offering their services to NHS patients. It is totally unacceptable that such information is currently kept from the public.

PATIENT REPORTED OUTCOME MEASURES

So far, despite the advances I have referred to, not much information is available which really helps the patient make in informed choice. Outcome data currently focuses on mortality and readmission but that excludes the vast majority of hospital admissions. It is also the case that PCT's have little information of real value that they need to effectively commission services based on quality.

Yet there is real scope for empowering patients – and guiding PCT's - by providing better quality information about hospital and GP care. One option would be to publish what are known as 'Patient Reported Outcome Measures' (PROMs). This

approach involves measuring actual patient experiences and assesses whether the treatment has actually benefited them in terms of their physical and mental health. BUPA has developed the use of this approach in order to measure quality of outcomes in their hospitals (prior to sale). Both for organisations and for patients, this sort of information can be invaluable for driving up quality of care and for empowering patients.

Patient reporting could also be a powerful force in the drive to improve patient safety in the NHS.

PROGRAMME BUDGETING

Programme budgeting is another valuable development which has the potential to empower local health boards - and individual citizens, to hold their health board to account. The principle is that for the first time, using programme budgeting, we can see where the money is going and what we are getting for the money invested in the NHS.

The project, initiated by the Department of Health in 2002, maps 'all PCT and SHA expenditure, including that on primary care services, to 23 programmes of care based on medical conditions such as mental health, cardio vascular disease and cancer. The focus on medical conditions clearly forges a closer and more obvious link between the object of expenditure and the patient care it delivers'.[xv]

In effect, one can compare, on-line, expenditure on a particular medical condition in one area with that in another similar area and then compare health outcomes. The project is still in development, and the information is only as good as the quality of data collection but its potential is considerable. It allows you to ask the critical questions. Why is one area apparently achieving far better outcomes than another given the level of resources invested?

But despite all this expansion of access to information, it is unlikely to be enough to empower all citizens. Not everyone has access to a computer or can interrogate information effectively. Patients often need a healthcare professional to interpret information to best effect.

How best can you ensure that all patients both have access to information and to support and advocacy? Certainly, the GP has a critical role to play in guiding the patient and in acting as their advocate. However, their time is often too limited to do this effectively enough.

PATIENT ADVISERS

The most common point of contact for patients with the NHS is their GP's surgery. There should be someone based at the surgery (subject to availability of space) that is available to provide information, guidance, advice and support. The voluntary sector could play a part in providing this service. Age Concern, Citizens Advice and other voluntary sector organisations already provide support in many areas. Their role could be developed to provide a universal service accessible via the GP surgery. The adviser may be nurse trained and it is clear that much can be gained by empowering nurses to provide a range of clinical services and to act as point of contact for patients. The adviser's role would not just be to help in the choice of hospital. Those with chronic conditions often need guidance on self-care. Patients and carers are left bewildered by the divide between health and social care and by matters such as entitlements to benefits, transport to hospital etc. The adviser could guide the patient through the full range of health and care options.

Many carers also feel isolated with no information about support services, their rights on access to respite care and so on. A Patient Adviser accessible via the GP's surgery could help guide carers through this minefield. Patients and carers should be able to make contact with the adviser by both telephone and email. Pilots should be established to determine the most effective mechanism for supporting patients and carers in this way.

If choice is to be made a reality for low income groups, more effective and easily accessible assistance with travel costs, for those who can't afford it, has to be available.

PATIENT RECORDS

Patients should also be advised about the right to access to their medical records. In a survey in 2004, only 28% of respondents in the UK said they could access their medical records – this is despite the fact that a statutory right of access already exists. This compared badly with other countries. Yet, according to the Picker Institute, nearly two thirds of patients said they would like to be able to access their records.[xvi]

NOT JUST CHOICE OF HOSPITAL

The Labour government claims to champion the 'choice' agenda. But it is a very centrally constrained concept of choice. 'Choose and book' gives the patient a choice of 4 hospitals, one of which will be in the private sector. The government's

approach to 'choice' has more to do with applying market forces to providers in order to make them more efficient – rather than genuinely empowering patients.

For Liberal Democrats, this is wholly inadequate. Patients should have a right to be involved in the decision about which specialist they should be referred to. They should have the right to wait longer, if they wish, to see the right specialist for their condition – even if this conflicts with centrally imposed targets for waiting times. They should have a say about the treatment choices which may be available. And those with chronic conditions should be empowered to self-care more effectively with the necessary support.

An international study comparing five countries (New Zealand, Australia, USA, Canada and the UK) found that the UK was the worst at involving patients in choices and in advising patients on healthy choices.[xvii]

If you are engaged in your own healthcare and in the choices available, then you are more likely to take responsibility for your own health than if you are simply told what is going to happen to you. The Wanless Report in 2002 estimated that the cost of *not* involving patients in their own healthcare could be as much as £30 billion a year by 2022. He highlighted the absolute importance of developing self-care. This is particularly important for those with long term chronic conditions. Improved self-care could have a significant effect on productivity in the NHS, whilst at the same time help people to take control of their lives. Wanless called for investment in effective health promotion and disease management with the active involvement of individual patients – and local communities. Expert patient initiatives can be cost effective and should be further developed.

International comparisons show that far more could be done in the UK to engage patients in their own healthcare. For those with chronic conditions, regular medicines reviews with a health professional are very important. Yet in a 2004 survey, British respondents were less likely to report having had such a review compared to other countries. In 2005 a survey of sicker patients showed that significantly fewer patients had benefited from a review compared to Germany and the USA.[xviii] Progress is, however, being made in the UK. Incentives have now been introduced to encourage pharmacists to undertake medicine reviews but the take-up is still quite slow.

Health professionals in the UK could also do far more to get across important advice on healthy living etc when they see their patients. In 2005, a sample of sicker patients was asked if they had had advice on diet and exercise from any health professional in the previous year. Results for the UK were much more negative than in New Zealand, Canada, Australia and the USA. Only Germany was comparable. Results for the general population were similarly very negative in terms of advice

on weight, diet and exercise.[xix] This suggests that real opportunities are being missed.

GPs could be incentivised to use such opportunities to provide guidance and advice to patients.

Our proposed Patient Advisers accessible via the GPs surgery could make a real impact in improving the UK's performance. Pharmacists can also play a much enhanced role in preventive medicine.

PATIENT ENTITLEMENTS

As part of the ambition of empowering patients there should be a declaration of entitlements that every citizen, wherever they live in the UK, has, as of right. These would enshrine the core values of the National Health Service. National entitlements would only be set after consultation with local health boards. However they would provide an important reassurance that decentralised accountability and responsibility will not lead to loss of entitlement. Indeed, I believe that a decentralised NHS will, in time enhance the effectiveness of the service. I envisage a competitive localism – where areas seek to demonstrate that they can out-perform other areas – in place of the dependency culture which now exists where we all blame the Government.

Nonetheless, in a *National* Health Service there should be a set of universal entitlements – a contract between the NHS and the individual patient which also sets out the patient's obligations. In Denmark, a far more decentralised system, each citizen is entitled to their operation within two months of diagnosis. If the operation has not happened at that point, they can have their operation in a private hospital, paid for by the state. Whilst there are legitimate concerns that this sort of entitlement can distort clinical priorities, we were told by health economists in Denmark that this was the single most effective means of driving up efficiency in public hospitals. We should find it unacceptable that we are still waiting so long for many operations. The Government has set an 18 week target (from GP referral to treatment) for next year but recently published figures suggest that in some parts of the country, the target is still far from being met. We should set a time frame for successive reductions but this should be based on a citizen's entitlement – similar to that in Denmark.

A Liberal Democrat patient's contract could include:

- Rights to accurate and relevant information;
- Rights to advocacy and the right to make their own decisions about their healthcare with advice and support of health professionals;

- Rights with regard to redress;

- Maximum waiting times – patients being entitled to the same right to treatment in a private hospital if they have not had their operation within a specified timescale as applies in Denmark;

- Access to treatments recommended by NICE[xx] and access to core services such as sexual health services, drug and alcohol treatment, mental health services and services for those with chronic conditions as defined from time to time by Parliament;

- Access to GPs;

- Out of Hours Care standards.

I advocate the establishment of a Constitution for the NHS enshrining its core principles and setting out what citizens are entitled to expect – and what their responsibilities are. We will develop specific proposals over the next few months.

THE ROLE OF DIRECT PAYMENTS AND INDIVIDUAL BUDGETS

The Department of Health says that 'direct payments create more flexibility in the provision of social services. Giving money in place of social care services means people have greater control over their lives, and are able to make their own decisions about how their care is delivered'.

This glowing endorsement of an approach originally pioneered by disabled people themselves in the US does not, however, stretch to health care. Yet there is no reason why the same principle cannot be applied to certain aspects of health care. There may be scope, for example, for extending direct payments to the care of those with chronic long term conditions.

There is clear evidence that direct payments lead to greater user satisfaction, better continuity of care, fewer unmet needs and to a more cost effective use of limited public funds. (see Bornat and Leece, 2006; Glasby and Littlechild, 2002). The key point that appears to emerge is that the recipient of the direct payment has a greater vested interest than the local authority in ensuring that every penny is spent as effectively as possible. Crucially the direct payment gives control to the disabled person in determining their priorities.

The development of individual budgets is perhaps even more interesting. This approach was introduced by the Department of Health in 2003 and pioneered by a number of local authorities and Mencap. The idea is that the authority identifies at

the start the amount of money available for an individual's care. Then that individual and their family can decide for themselves the degree of control that they want over how that money is spent. Early evidence is positive. Individual budgets appear to result in much higher satisfaction levels, improved efficiency in use of available funds and increased use of community and personalised support. (Poll et al, 2005). Of great interest to Liberal Democrats is the fact that they appear to empower people in the use of social care. 'A massive proportion of people in the early pilots were able to achieve the changes they wanted to achieve in their lives over the course of one year.' (Glasby and Duffy, August, 2007) No longer are individuals passive recipients of a service handed down from on high. They are now in control.

And yet, this whole approach does not filter across into health care. It seems entirely consistent with the principles set out in the White Paper, 'Our Health, Our Care, Our Say' and yet there is a resistance to explore its potential.

Glasby and Duffy make the point that recipients do not make a distinction themselves between heath and social care. A study by Glendenning in 2000 found that individuals receiving social care direct payments actually used the payments to fund health services such as physiotherapy, nursing care etc. The individuals themselves blurred the distinction between health and social care. They used the payments as they themselves saw fit to achieve maximum advantage.

A study this year in the US has also highlighted the real potential benefits that could be achieved if individualised funding was introduced into the NHS (Alakeson). Not only can this secure better value for money and more transparency in the use of resources but it also puts the patient in charge. They can make their own decisions. There is also evidence that it leads to greater innovation in the development of services.

Glasby and Duffy propose that individual budgets and direct payments should be piloted in a number of areas such as services for those with long term conditions, mental health services, maternity services – to hire an independent midwife to give the woman a birth of their choosing, continuing health care and services for people with learning disabilities.

This approach has a lot of merit. Such pilots should be pursued.

OTHER OPTIONS FOR SERVICE DELIVERY

Local Health Boards may wish to consider other innovative mechanisms for service delivery in defined areas of care. Eye care may provide a model which can be used elsewhere. Those entitled to NHS support can obtain glasses up to a specified

value, with the NHS paying the optician. This gives the citizen choice within a price bracket of glasses to purchase – and a choice of which optician to go to.

The same principle could perhaps apply to the supply of digital hearing aids. At present, there is a waiting list of some 166,000 people[xxi] – and in parts of the country delays can stretch over two years. So if you cannot afford to get your hearing aid privately, you are left waiting unacceptably long.

Private providers have argued that they could provide and fit digital hearing aids at a lower cost than the NHS and without lengthy delay. They could offer the service on the high street, accessible for most people. Already, anyone with money can opt out of the waiting list and access this service. It should not depend on your income in this way. A local health board could commission digital hearing aid services from a number of providers able to meet quality and price standards. It is right to acknowledge that there are concerns about the potential impact on the viability of NHS audiology departments and these need to be fully considered.

EFFICIENT USE OF RESOURCES

There is a widely held view that the extra investment in the NHS could have achieved a greater advance in health outcomes and that resources have not been utilised efficiently. It should be possible to achieve significant efficiency gains. This is important because all money wasted is money that is not going into patient care.

Effective commissioning is also critical to securing improved efficiency from providers. The importance of commissioning has been badly neglected until now. All the attention has been on providers. Under these proposals, health boards, as commissioners of healthcare, must ensure that they are securing the best deal for their community. Contestability is clearly important. Liberal Democrats should accept a diversity of providers. But the health board also has to ensure that local services remain stable.

It is also the case that the principle of money following patients seems to incentivise hospitals to improve efficiency.

Local health boards would be subject to a statutory duty to demonstrate efficient use of resources – value for money.

Health boards would also be subject to inspection and audit by a national standards agency such as the Audit Commission – just as with local authorities.

NATIONAL INDEPENDENT BOARD: THE ARGUMENT

On the face of it, the idea of removing politicians from the day to day operation of the health service is a seductive option. But the problem is that the stewardship of the NHS necessarily involves political judgements. In today's highly centralised NHS there is already a sense of a real 'democratic deficit'. The battle-worn former Health Secretary Patricia Hewitt, acknowledge this in a speech shortly before her departure.[xxii]

Liberal Democrats should resist any reform which creates a new, powerful, centralised, and unaccountable body which micro-manages local health service delivery. Remarkably, the Conservative proposals for the NHS, envisage a national board having the final say over closing an individual Accident and Emergency unit anywhere in the country.[xxiii] This would cause enormous anger on the part of local people who would inevitably complain that an unaccountable, remote quango in London was deciding the future of their hospital.

For Liberal Democrats, the question should be what structures should exist nationally in a far more decentralised NHS.

First of all, the Department of Health should be slimmed down substantially. Even Labour in their 2005 Manifesto stated: 'We are decreasing the number of staff in the Department of Health by a third'. It has not happened. In January, 2005 there were 2341 permanent (full-time equivalents) members of staff. By January, 2007 the total had reduced by just 85 to 2256. But there were also another 230 contractors and agency staff working there. The Department should focus primarily on public health, workforce planning and training.

Secondly, the existing arrangements with regard to the relationship between ministers and the management of the NHS has to change. There is a total lack of openness which Liberal Democrats must challenge. As Professor Brian Edwards puts it in his review of options for an independent NHS,[xxiv] 'The current NHS headquarters are a closed part of central government. Ministers and their officials meet in private, as do the Chief Executive and his top team, and minutes of their meetings are not available for public inspection. Contact with the public is via press releases and the broadcast media, and is controlled'.

We must therefore open up the governance of the NHS at a national level. I believe there are two potential options – out of a number examined by Professor Edwards in his Nuffield report - we should consider.

MODERNISED NHS EXECUTIVE WITHIN THE DEPARTMENT OF HEALTH

In this option, the NHS Executive would be formally constituted within the Department of Health. It would be charged with overseeing the work of the local Health Boards, providing guidance on best practice in commissioning and allocating funding to local Health Boards. There would be a formal scheme of delegation with clarity as to matters reserved for Ministers. The Executive board would meet in public and publish reports and minutes.

The disadvantage of this arrangement is the risk of ministers straying over the line and interfering constantly with the work of the Executive. It may not be a sustainable model.

AN NHS COMMISSIONING AND ADVISORY AUTHORITY

This option would be for a body operating at arm's length from the Secretary of State. There would be a board, appointed by the Independent Appointments Commission, which would meet in public and publish minutes and reports. There would be a constitution. Its functions would be similar to those described in respect of the first option – an NHS Executive. The authority would operate within a

broad planning and financial framework, which would be agreed by Parliament and embodied in a publicly available, annual memorandum. The allocation of funds would be on the basis of a formula set independently and again approved by Parliament. Its focus would be on building best practice in commissioning.

This model has the advantage of clarity in terms of the relationship with ministers. It would be less susceptible to political interference. It would not, however, be involved in local decisions about the provision of services.

This may be the most open and accountable framework in an NHS enjoying new, local democratic accountability.

HOSPITALS AND SERVICES PROVIDED CLOSER TO HOME

There are two developments which Liberal Democrats need to consider. First, the Government is pursuing a determined push to encourage all NHS trusts to apply to become NHS Foundation Trusts. Liberal Democrats have concerns about the model of foundation trust developed by the Government. However, we support the principle of giving hospitals and mental health trusts greater autonomy to run themselves and to be free from Whitehall control and performance management by Strategic Health Authorities. We should support a model which gives all hospital trusts freedom to access capital on the basis of affordability. And they could invest surpluses in developing new services for the local community.

There is a disturbing trend of some Foundation Trusts excluding the public from board meetings and refusing to make minutes of meetings available. This should not be permitted. There should be clear rules requiring Trusts to operate in an open and accountable way.

The second development is the shift of services out of acute hospitals and closer to people's homes. This is a trend we should endorse. It is of course important to acknowledge that there are services which are not appropriate for such a shift. Acute hospitals however should focus on those specialist services which have to be based there.

In Cornwall and Isles of Scilly, the Primary Care Trust has produced a blueprint for developing health services for local communities. They did this after extensive consultation with patient groups and the general public. Their plans are based on offering more healthcare closer to where patients live. It is a fascinating pilot which has wide application elsewhere – both in rural and urban areas. They make the point that they can achieve maximum value for money for local patients, they can tackle inequalities – travel costs are a significant burden for low income households – and they can reduce their carbon emissions and promote sustainability. This is enlightened policy making.

CONCLUDING COMMENTS

In this paper, I have attempted to map out a clear way forward for the NHS based on Liberal Democrat principles. We believe fundamentally in the core principles of the NHS. The challenge is to ensure that the NHS is sustainable. The big increases in funding have come to an end for the moment. We must therefore ensure that we achieve maximum value for money so as to achieve the best possible health outcomes. This cannot be done by top down, command and control.

The objective must be to empower local communities, health professionals and managers to secure responsive, local and high quality health and social care. We must work towards ending the divide between health and social care so that seamless services are provided to patients. And we must empower individuals to be fully engaged in their own health care, not passive recipients of what is handed down to them. But in a national health service, there should be core entitlements that every citizen has the benefit of. There is more work to be done but I hope this provides a good starting point.

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