A new health service: what kind of health service do we want?

A discussion document

Sally Ruane

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FOREWORD

I was unable to attend the KONP conference reported here, but its subject was the most important issue now facing everyone concerned to defend the NHS as a public service: how to connect the few hundred who are familiar with high policy, and think in political terms, with the millions who experience personally the effects of industrialisation and commercialisation, but have turned away from politics in disgust.

Finding a way to begin this journey toward a potentially huge movement is a complex and difficult task. We face a new situation, with no map to guide us. Discussion at the conference obviously wandered all over the place, trying to find outlines for a new map, and it probably pushed aside a good deal of rubbish. Other people attempting this formidable task will face the same initial problems. Reading this report could help them to look for sound foundations for the new social solidarity we all need.

We need to bear in mind some strange anomalies we have known for a very long time, but have seldom taken so seriously as they deserve. As all progressive professionals know, healthcare of any kind can be provided more effectively and efficiently by multidisciplinary groups than by single-handed medical shopkeepers. Ever since 1948, progressive professionals have regarded the huge decline in single-handed general practice, and the rise of ever-larger group practices, as a measure of progress. Yet whenever we ask people what they want, what they look for from primary care, they express preference for GPs working in small single-handed units, with one or two supporting staff, who know all the patients, know their life stories, and know the home and work context in which their problems have somehow to be solved. Similar gaps appear if we compare Public Health approaches to care, and public expectations for personal prevention or cure.

If the ideal NHS as conceived by progressive professionals is quite different from the ideal NHS conceived by the general public, we shall fail. In which case, the market will move in to take what it wants, leaving some sort of hand-to-mouth dog's dinner of charities to deal with whatever remains. We must find ways to discuss the ideas presented in this report more concretely, to connect with the experience of both staff and patients unaccustomed to discussion in academic terms. This report makes a good start.

Julian Tudor Hart

Retired GP, Research Fellow Swansea University Medical School. March 2009

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I INTRODUCTION

This discussion document is based on an analysis of the ideas and observations of participants in the national Keep Our NHS Public Workshop, held in Leicester in November 2008, entitled 'What kind of health service do we want?'. The workshop was underpinned by the belief that, although much health service campaigning is characterised by fairly defensive approaches designed to combat privatisation and the extension of market principles, an effective campaign requires a *positive* vision of what is being campaigned *for*. The workshop offered campaigners the opportunity to discuss and develop ideas about the kind of health service we should be trying to build and attempted to establish whether there was a consensus or 'common sense' among campaigners as to the kind of positive policy agenda we should be developing. The report provides a summary and organisation of the ideas expressed in small group discussions and some suggestions for further work. The boxes identify notable areas of agreement and contain recommendations/views of two or more groups without dissent from other groups.[1]

The views and ideas recorded here are not a statement of Keep Our NHS Public policy but are presented as a basis for further discussion among those who care passionately about the future of our health service.

II SUMMARY POINTS

The workshop established some of the key pillars of a reformed health service. It should

- Be democratically accountable
- Be integrated and based on cooperation and planning
- Devolve much greater decision making to a local level
- Be available on the basis envisaged by Bevan: universally and according to need alone
- Be publicly provided and funded
- Work closely alongside social care services
- Build in staff representation locally

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[1] There were four small groups, each of which discussed questions under two themes. The appendices include a list of participants in the workshop (App I) and the questions proposed to frame small group discussions (App II).

- Be more responsive to the community

The workshop also revealed a vision of a much more holistic, social and integrated approach to health policy which should:

- Place a greater emphasis on prevention of illness and health promotion, including through population level interventions
- Adopt social policy measures which create a more egalitarian and less consumerist society
- Ensure that the bringing up of children is a highly valued and protected activity
- Inform all other areas of policy making through greater integration of some form of health impact assessment
- Toughen the regulation of business practices of relevance to health

III CORE PRINCIPLES

The following core principles were established prior to the workshop and no dissent was expressed. The service should be:
Universally available and on the basis of need alone
Publicly owned and publicly provided
Planned, integrated and rational
Democratically accountable

This additional principle emerged from the workshop:
The healthy society should be a key organising principle across all public policies.

The Alma Ata Declaration also offers guiding principles, specifically the following:
"…health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease and infirmity, is a fundamental human right"
and
"The people have the right and duty to participate individually and collectively in the planning and implementation of their health care" (Declaration of Alma Ata, 1978: Points I and IV).

IV THE REFORMED HEALTH SERVICE

Broad structure

The market in health care and the purchaser-provider split should be abolished, along with competition. In its place, an integrated, planned and co-ordinated service should be established. Health and social care should work in partnership or even be merged.

Serious consideration should be given to the merger of the NHS and social care into a Health and Social Care Service.

The abolition of the market will require a new financial system for channelling funds through the organisation. An examination of the current system in Scotland and the previous system in England (prior to both the market reforms of New Labour and the internal market reforms of the Conservatives) should be undertaken to see how these systems could be improved in our reformed service.

Democratic Accountability

Democratic accountability is essential and should form one of the fundamental tenets of the service. Democratic accountability should entail both representative and participative approaches and the principle of subsidiarity should apply – that is, decisions should be taken at the level closest to those affected consistent with the principles of good governance. This represents a shift of power to the local level. Broadly, a national-regional-local structure is envisaged. Elected local boards managing and planning local services should be the principal bodies through which health services are organised and through which they are held to account. These, and institution-level boards, should include representatives of the public and representatives of local health service workers.

Consideration should be given to the following structure:

- Institution level boards
- Local - City-region boards (e.g. Leicester and Leicestershire)
- Regional - Joint local bodies (e.g. Midlands or E Midlands)
- National

Here, the principal power rests with the local bodies which collaborate to form the regional structure where services need to be planned and organised on a regional basis. Local bodies should be composed of democratically elected members and should include representation of both local public (on an areas basis) and local staff. The precise composition of local bodies, as well as effective forms of consultation, should be considered in more detail and it may be worth considering models from elsewhere.

The precise remit and powers of each level have yet to be worked out. The national level should include the establishment of minimum standards.

Institution level bodies should include representation from the public and staff.

Thought needs to be given to how community power is represented and articulated both in the democratic participation of running the local institutions and the local boards and in engaging with health care staff around the implementation of particular aspects of patient care. Consideration should be given to patient participation groups in which ‘expert patients’ develop a growing body of knowledge which can be used both to influence the planning of services and in the development and implementation of particular service programmes. A body similar to the Community Health Council (but avoiding the CHC’s weaknesses) should be established to correspond with local boards and regional bodies. The CHC could serve both monitoring and user-representation functions. Other mechanisms for representing user perspectives should be considered.

Rationing and Resource Allocation

Funding should be allocated through a needs-based approach, not an activity-based approach. NICE’s remit should be retained in some form as rationing decisions are unavoidable. NICE should be extended to other areas of activity.

NICE – or some similar body – should be retained but the advantages and disadvantages of separating assessment of clinical effectiveness from assessment of cost effectiveness and making rationing decisions should be reviewed. Decisions taken by NICE should be implemented at the local level so that all those in need of and prescribe approved treatments can receive them. The body should operate at a national level but mechanisms for increasing its accountability to the public need to be considered. A similar body should be established to assess the effectiveness of public health or preventative measures. Another similar body could be established as a source of expertise on other sorts of evaluation matters such as the configuration of services, since service planning and configuration should be evidence-based.

Local resources will vary according to needs assessment and local services will vary according to health needs. Resources should be used in ways which are effective and accountable.

Delivery of health services

All health care workers, including professionals, should be salaried employees. There should be a greater emphasis on interventions at the population level rather than at the level of the individual.
Parts of the health service should be connected through an IT system which would also allow patients to access their records. A list-based GP system should be maintained. The relationship between the community and the health care system needs to be strengthened

Services should be organised around care pathways and clinical networks should develop to support this. Managers and clinicians should work in equal partnership to strike a balance between individual patient care and cost effective use of resources. Innovation and service development should be the norm.

Not all health services can be delivered in the 'community'; some will be delivered in hospital or other buildings and the configuration and location of services should be evidence based. This could include polyclinics where the clustering of services is evidence based and appropriate to local health care needs. Non-invasive ways of reaching out to patients who are infrequent users of health services should be explored and this may involve non-clinically trained personnel working alongside GPs. Health care buildings should be healthy buildings with healthy employment policies and healthy food policies.

Overall, services should be more prevention orientated and mental health should receive a greater share of available resources.

Pay bargaining should be national even where services are locally managed and planned.

Charges should be abolished.

The concept of choice needs to be reclaimed and redefined in a way which is consistent with the principle of equity and which addresses health needs more effectively. Choice will not be offered or expressed in a competitive environment and the aim will be to have excellent services locally. More information should be made available to patients about how to lead healthier lives as well as to enable them to assess whether they wish to have treatment at all and, if so, which treatment they wish to have.

Choice can mean little where patients and doctors have limited relevant information. In addition, choice has the potential to exacerbate health inequalities and other inequalities so it needs to be defined and expressed in a reformed service in a way which avoids these pitfalls. Among common conditions, best practice should be instituted and the routine evidence based management of care and treatment will be more important than choice. The expectation is that most routine health care will be accessed locally. This requires up to date information, adequate resources and time and the right facilities. Choices can be

influenced by media reporting which exaggerates the benefits of particular treatments and patients need to be better informed, especially about alternatives in end of life care.

The guiding and advising role of the GP will be important in the exercise of choice.

Partnership in the delivery of health care and the promotion of good health

Further discussion is required to establish the best way of organising services vis a vis the need for local authority and health service collaboration. One aspect of this is the relationship of health and social care and consideration should be given to a possible merger of health and social care.

A second aspect of this relationship concerns the planning and delivery of health promotion and public health measures. There is a need to assess vigorously the relative clinical effectiveness and cost effectiveness of social (public health) interventions and medical (primary healthcare) interventions for illness prevention and health promotion. The increasing trend to medicalise and medicate risk-factors for ill health (including stress, obesity, inactivity, cholesterol) should be challenged since this results in the creation of disease as a consequence of the chosen medical/pharmacological solution. Whilst primary care has a responsibility to promote and support healthy lifestyles, it should focus on managing illness, whilst public health should have the main responsibility for promoting health.

V A SOCIAL APPROACH TO HEALTH

Creating a healthy society and making health central to all policy making

An holistic approach (that is, one that recognises that impact of social factors on health) is required both to tackle ill-health and to promote more healthy living. This entails a cultural shift which includes a move away from competition and consumerism and towards cooperation and citizenship. Institutions central to healthy living include the family and the school.

Health is a social as well as individual phenomenon to be addressed, promoted, safeguarded and sustained through a wide range of social policies and social interventions. Health is shaped at least as much by environmental policy, housing and transport policy and redistribution through the tax and benefits system and so forth as it is through health service interventions. Consequently, there is the need to subject all policies to some form of health impact assessment so that all policies are pro-health. Some policy areas could be more integrated.

Health considerations should be part of policy making across the board. This includes consideration of the health impacts of specific policy areas such as transport, food policy, housing, employment, education and leisure at both national and local levels. A portion of

the budgets in these policy areas should be used to address health impacts. Greater consideration should be given to the healthy cities initiative. Tougher regulation of business should be introduced in relation to advertising, the labelling and contents of food and the availability of cheap alcohol.

Consideration should be given to the appointment of a minister for Public Health at a Cabinet level who is charged with ensuring increased health promotion and a healthier society. S/he would require access to all departments of state and would be able to influence them all at a national level – including environment, (waste disposal, pollution, DEFRA, food), health transport, housing etc. At local level, a parallel system could develop with Local Authorities appointing local Directors of Public Health who have the same level of access to and influence in all departments.

Health and healthy living can only be produced and sustained in a much more egalitarian society. Reduction in inequalities in both income and wealth is essential prerequisite to a healthy and cohesive society. Thus, significant redistribution is required through a much reformed tax and benefits system.

Non EU citizens should be allowed free health care when in the UK.

The family is central to maintaining physical and mental health and to passing on knowledge about healthy living. Parenting and caring should be recognised as critically important roles.

Parents should be offered financial support to make staying at home to look after children a feasible and realistic option. The policy bias towards encouraging participation by parents in the labour market needs to be redressed although where parents want to work, this should be facilitated. The 'long hours culture' should be challenged and a debate should be initiated regarding the benefits and disadvantages of the 24/7 culture.

Community sources of support for parents, the isolated and those suffering health problems should be developed, for instance via expert patient groups which lead to knowledgeable citizens.

The centrality of schools to a health promotion/illness prevention strategy should be recognised. Schools should be places where children learn self-care and healthy behaviours and where they are able to take exercise.

Schools are central institutions for developing healthy behaviours – they are places where children can be taught good self care, healthy eating, including food production and cooking, exercise, good dental care and care of the environment. Every school should have good fitness facilities and local playing fields should be retained. Sport and health need to be embedded in all education policies and should be reflected in the curriculum. Sporting activities should be enjoyable and allow all to take part and do well; local paying fields and leisure centres should be retained. Educational targets should be more holistic, preparing

children for life. Education should become less exam driven and less stressful for children and young people.

Consideration could be given to linking vaccination systems to school entry and screening should be expanded. A proper awareness of public hygiene should be restored, including through simple posters with simple messages.

VI NEXT STEPS: SOME AREAS FOR FURTHER WORK

The Keep Our NHS Public workshop is one of a number of recent attempts by a range of organisations to deliberate alternatives to the current paradigm in health policy. There is a need now to circulate for further debate the ideas and principles which have emerged. Where appropriate, this should be done taking into consideration (although not be constrained by) relevant concepts and ideas being discussed and developed elsewhere.

Further **deliberation** by Keep Our NHS Public is required on:

- The precise structures to be established to secure democratic accountability. This deliberation should take into account developments in Wales and Scotland as well as the structures used in selected EU countries. The work of Democratic Health Network, NHS Alliance & Socialist Health Association on accountability should also be taken into consideration.

- The arguments for and against a merger between health and social care to create some kind of local health and social care service.

- The reintegration of the health service and abolition of the market structure, which should not simply assume a return to the *status quo ante* but should examine how the previous system can be improved upon. Studying the Scottish health service could help here.

- Reforms to the tax and benefits system which will bring about a more egalitarian society. The work of the Compass Tax Group, Richard Wilkinson and the new Equality Trust should be taken into consideration. This will be connected to restoring a progressive tax basis for funding the health service, including alternatives to the Private Finance Initiative in capital investment.

- Developing stronger community mechanisms to support patients and citizens likely to benefit and to engage with both the implementation of specific health policies and the shaping of overall policy (i.e. at the system and programme levels).

- Specific approaches to building health considerations into other areas of policy. This would take into consideration the work on health impact assessment currently undertaken, for instance, in Liverpool.

The **dissemination** of ideas is an essential part of attempts to shape the policy agenda. Keep Our NHS Public should consider ways of disseminating the broad ideas reported here and drawing others into discussing them. The superiority of a publicly funded and publicly provided health care system should not be assumed but should be explicitly articulated and disseminated.

The workshop has attempted to draw grassroots campaigners into a process of bottom-up policy deliberation. The further development and firming up of policy proposals should continue to build in **democratic** process.

VII GIVING FEEDBACK

If you would like further information or to respond to any of the ideas expressed in this discussion document, please send your views, indicating where relevant the organisation you belong to, to:
Sally Ruane
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Appendix I Workshop participants

The workshop was attended by 33 participants who included current and former health service workers as well as community activists; all were service users. Participants attended from Tyneside, Greater Manchester, Nottingham, Birmingham, Oxfordshire, Northampton, London, Grantham and Southend as well as Leicester and Leicestershire. Most participants were white. There were 14 men and 19 women; ages ranged from (at a guess) eighteen to eighty. Participants included members of the BMA, GMB, MPU, NUT, RCN, Unison, UCU and possibly other organisations. All participants are health campaigners and NHS patients. The following have indicated their willingness to be identified.

Wendy Savage (facilitator) (London) (Keep our NHS Public Chair)
Doreen Crawford (rapporteuse) (Leicester) (University lecturer; RCN and UCU member)
Viv Addey (Leicester) (Network; former NHS employee)
Martin Rathfelder (Manchester) (Director, Socialist Health Association)
Norman Traub (Southend) (retired consultant haematologist)
Morag Forbes (London) (midwife and IWW member)
Denise Wood (Leicestershire) (Save Our NHS, Hinckley and Bosworth; graphic designer; member, National Pensioners Convention women's working party)
John Lipetz (facilitator) (London) (retired NHS primary care manager)
Helen Groom (rapporteuse) (Tynemouth) (GP)
Robert Jones (Banbury) (retired Computer Services Manager)
Verity Kirkpatrick (Birmingham) (health care assistant and IWW member)
Jonathon Tomlinson (London) (GP)
Ron Mendel (facilitator) (Northampton) (President Northampton Trades Union Council and Chair of the Northampton Save Our Services, Save Our NHS)
Mina Rogers (Leicester) (Unison Leicestershire Health retired section)
Pauline Cutress (facilitator) (Leicestershire) (Save Our NHS, Hinckley and Bosworth)
David Byrne (rapporteur) (Gateshead) (Prof Applied Social Sciences, Durham University)
Fran Hook (London) (former nurse and midwife)
Becca Kirkpatrick (Birmingham) (lab technician (Blood Service) and union activist)
Charmaine Morgan (Grantham) Chair SOS Grantham Hospital
Alan Stanley (Leicester) (Treasurer, Leicester and District Trades Union Council)
Sally Ruane (Leicester) Workshop organiser and facilitator – (health policy academic and member of UCU)

Appendix II Small Group Discussion Themes

The flyer advertising the workshop referred to these **principles**:
"We know we want the service to be

- universally available and on the basis of need alone
- publicly owned and publicly provided
- planned, integrated and rational
- democratically accountable"

Moving away from sickness towards prevention and health promotion

- Mechanisms for transferring greater proportion of the budget towards health promotion and prevention

- The organisational structure of a health- rather than sickness-focused health service (including the configuration of services)
- What is the right balance between prevention and cure?
- What principal social and economic policy changes are required to promote health?

Health inequalities and resource allocation

- What kind of planning and resource allocation structure should replace the market structure?
- Principles underpinning spatial resource allocation
- Criteria for rationing at a local level and among patients
- The role and scope of patient choice
- Role and scope (if any) of patient charges and top-ups
- Principal changes required in wider social and economic policies to tackle health inequalities
- Should we distinguish between EU citizens and non EU citizens on questions of entitlement?

Producers of health care services

- Rights of workers to influence policy within their own organisations
- Bargaining structures
- Desirable alternatives to the compromises made by Bevan in relation to professional power
- Who are the 'employers'? What should be the employment status of professionals?
- Acceptable differentials between the highest paid and lowest paid in health service organisations
- How should the interests of users and producers be mediated/ balanced?
- What sorts of rights should patients have to participate in health care decision-making?
- Should we use the language of 'choice' or the language of participation or both?

Democratic control

- Policy-making structures and what sorts of policies should be decided at a national level and what at a local level?
- Should structures of decision-making and accountability for health be merged with new structures for other areas of policy (e.g. fall under local authority control)?
- What bodies, if any, should be elected?
- Role of trade unions and professional associations in decision-making at organisational, local and national levels
- What would be an effective replacement for Community Health Councils?
- What would meaningful public consultation look like?

ACKNOWLEDGEMENTS

We are grateful to the Leicester and District Trades Union Council for its support for this project and to the TUC for financial help. We would like to thank Jennie Fleming of the Centre for Social Action, De Montfort University, for her advice. We are especially grateful to the National Health Service Consultants Association for underwriting the publication of this report.

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