THE CHANGING SCENE AND CHALLENGES FOR HEALTH AND HEALTHCARE IN THE UK

This presentation will cover the reforms of the NHS in England, Scotland Wales and Northern Ireland, the shift of priorities to health and inequalities, tackling chronic disease and I will speculate on the future of disease prevention and promotion, improvement and protection of health and whether the past is any guide to the future.

When I was invited to take part in this seminar Professor Leeder suggested as a title- the destruction of the NHS and many UK newspaper headlines would support such a contention. On Monday 27 February the FT headlines were “Labour calls for health revolt- Lib-democrats urged to scupper NHS Bill”. That same weekend on the radio, Lord Crisp, former NHS CEO and Health Department Permanent Secretary described the Health and Social Care Bill as “a mess, unnecessary and in many ways missing the point”.

This is a view that I do not share and in part the problem is essentially forgetting whether the past is any guide to shaping the future.

LEARNING FROM THE PAST AND LOOKING TO THE FUTURE

In July 2001 WHO convened a Technical Group on strengthening capacity for policy development and strategic management .In its background paper it had a section on learning from the past and looking to the future and two perspectives on policy making and management of health systems. First the “technical aspects”– content and tool that policy makers could make use of to improve systems including health outcomes, effectiveness, equity in access, responsiveness, fair and sustainable financing and here I would rate the NHS Reforms in England well.

Second the “process of policy making” – ways in which agendas are set, the role of key actors or stakeholders and their power relations, understanding internal and external policy environments and the institutional, political, legal and cultural context in which policy instruments for change are being applied. The literature and experience has shown how vital it is to explore options and choices particularly to secure ownership of the policy process by those whose input is required to make the policy changes work. On this the UK Coalition Government has singularly failed.

On February 9 2012 in its Editorial the FT advised “a second opinion on NHS reforms; the UK Government should drop its misconceived bill”. The bill’s objectives are laudable according to the FT and if the NHS is to become more efficient there should be more clinical involvement in healthcare commissioning and politicians should take a back seat on provision, letting a regulated market evolve in place of top direction.

“But the Governments political courage has not been matched by political skill when it comes to execution. The bill’s author Health Secretary Andrew Lansley has alienated almost every interest connected with the NHS, in spite of last year’s ‘pause for reflection’ during which time he was suppose to reconcile opposition; even the RCGP whose members would be the biggest beneficiaries of the change are now against though more recently the President of the College of GP’s has qualified its position (letter to the Prime Minister 6 March). The problem is that seeking a compromise among many critics, the government may end up with passing a deeply flawed piece of legislation. For instance the demands to limit the role of the economic regulator may restrict the use of competition in ways which will not benefit patients.” This was one of the most contested parts of
the bill but is an England problem; markets, competition and choice are not the vocabulary of the rest of the UK!

THE UNITED KINGDOM - a reminder and lessons from Australia

When I returned to the UK after my time as DG NSW and Chair of AHMAC I was asked did I learn anything of value for the United Kingdom? My answer was that I had been an Administrator in a federal system and colleagues would go on - so what for the UK? I went on to commission a paper from the Constitution Unit at UCL – ‘Devolution the end of the National Health’ to help map out some health policy implications as the process of devolution got under way

Political devolution to the Scottish Parliament, the Welsh and Northern Ireland Assemblies, means it is now recognised that it is no longer possible to speak of a single NHS. The health services of England, Scotland, Wales and Northern Ireland are funded by the UK taxpayer but now have different systems of governance and pursue different policies. The hall marks of each are markets, competition and choice in England; Scotland benign professionalism; Wales- localism and citizen focus and Northern Ireland permissive managerialism.

In England following political devolution to the Home Countries, the purchaser/provider split- the internal market- has been maintained, coupled with robust performance management and financial incentives, complemented by encouraging completion between providers including new Foundation Trusts and independent sector treatment centres and promoting patient choice between them.

In Scotland and Wales the purchaser/provider split was abolished and health boards recreataed to meet population needs and run services within defined geographical areas- NHS Board in Scotland and Local Health Boards in Wales. Partly because of the troubles The health services in Northern Ireland were not subject to continuous structural changes and had pioneered integrated health and social care boards in the early 1970’s and following the Good Friday Peace agreement many health care services such as cancer care and public health were planned on an Ireland basis. In addition there have been other policy differences such as free personal care in Scotland and in Wales Northern Ireland and Scotland the abolition of prescription charges. All three countries have had stronger policy orientation towards health inequalities and public health than England.

According to the Health Foundation, which published a comparative and comprehensive analysis of quality, the crude conclusion of these various approaches to the NHS across 6 quality domains is that there is no systemic difference in quality across the four nations. However the Nuffield Trust in a comparative study shows that historically, Scotland, Wales and Northern Ireland have higher per capita funding than England which spends less, has fewer staff per capita and makes better use of its resources with higher levels of activity and productivity and lower waiting times. When comparing the Devolved Nations with regions of England that are similar on a range of health and socio-economic indicators, the analysis shows the differences to be more pronounced. The Nuffield Trust concludes this reflects the different policies pursued by each of the four Nations since 1999 and pressure on NHS bodies in England to improve through targets, robust performance management, public reporting of performance and financial incentives “including competition and promoting patient choice”. This conclusion was reinforced in an LSE study by Zack Cooper which reported that competition “could bring benefits to the NHS and that competition between public sector hospitals introduced by the Labour Government from 2006 produced non-trivial savings of 7%-9%”
An aside—as Scotland talks of breaking away and Wales; Northern Ireland increasingly run their own affairs; there are signs England is experiencing a growing nationalism of its own. How a referendum promised to the people of Scotland is handled—yes or no or devo-max—“could turn the face of the UK” (Andrew Bolger FT 17.2.2012) Again Phillips Stephens in the FT claims that Alex Salmond, Scotland’s First Minister’s insistence on a referendum provides a unique opportunity to modernise the constitutional landscape—a federal constitution he writes in the FT 21 February 2012. “Whatever the outcome of the referendum, the constitutional plates have already shifted. The past cannot be reclaimed. The choice has to be between designing a new landscape and leaving the task to Mr Salmond”.

HEALTH AND SOCIAL CARE BILL 2011

The bill to reform the NHS in England has had currently having a difficult time in the Parliament—the House of Lords in particular. The Government for its part claims that to safeguard the NHS and its future, it needs to change to meet the challenges it faces and only by modernising, can it tackle today’s problems and avoid a future crisis. The reform is taking place at a time of great austerity, a Euro zone financial crisis, rising unemployment, welfare reform, and rebalancing the economy from banking to manufacturing and a shift of the global economy eastwards. Australia seems to be done well as we were told by Kevin Rudd when in London recently at a speech at Chatham House ‘Fault lines in 21c global order; Asia rising and Europe declining’. The NHS budget has been protected (0.1% growth) but is having to take out £20 billion of efficiency savings to cope with health service inflation and demographic changes, most government departments have seen their funding cut by a third.

My last lecture here was on the theme of global health security at a time of economic vulnerability: issues for nation states and health policy. I argued that growth seemed unlikely to recover soon and that the debt crisis would constrain public finances for a long time, unemployment rising and civil unrest in cities across the world. I also recognised that overcoming the crisis would require well targeted fully coordinated efforts and that investment in health should be part of the response. Times of crisis are also times of opportunities in that governments may take action that might be otherwise be potentially infeasible and also offer a window to enact long needed but politically challenging reforms such as investment in public health, upgrading primary care, improving quality of care as a way of reducing costs as well as improving continuity of care. Health setbacks, I claimed in my 2009 talk, could be prevented or mitigated by increased health and public protection as well as efforts to strengthen health systems for the most vulnerable including tackling the social determinants of health.

One of the arguments for the bill is changing health needs and the challenges of managing care for people with long term conditions. Demands for NHS services are increasing as the population ages and long term conditions become more common. Despite living longer our communities are becoming less healthy—obesity costs the UK NHS £4 billion p.a. rising in the next 4 years to £6.3 billion p.a.; costs of medicine are rising at a rate of £600 million p.a. and more needs to be done to prevent illness; smoking costs the NHS £2.7 billion p.a. and there are wider economic and social costs from preventable ill health: drug abuse, overuse of alcohol; inequalities not reducing and in the period 2008-10 the gap between local authority areas with the highest and lowest life expectancy of 12 years for men and 11 years for women. These inequalities are happening at an austere time and the NHS needs better value for money.
HEALTH AND HEALTHCARE STRUCTURES

The Health and Social care Bill puts clinicians at the centre of commissioning, frees up providers to innovate, empowers patients and gives a new focus to public health and gets close to what the Secretary of State had in mind in opposition of renaming DH a great department of state for public health and placing the NHS arms length from politicians by having an NHS Commissioning Board. Most NHS care will be commissioned by clinical commissioning groups supported by the NHS Commissioning Board with clinical networks advising on single areas of care and clinical senates providing advice on commissioning plans. NICE will continue with an extended role in social care. Ministers in the Health Department will still be accountable for the NHS- a point clarified during the bill’s passage through Parliament. Action to protect and promote the health of the population will be led by a new public health service. The lead Agency – Public Health England will be an Executive Agency of the Department of Health.

I welcome the focus on public health and most of what I now want to say is about these changes and what they will mean for health protection, improvement and promotion and tackling the challenges of chronic disease in England. There are no structural changes in the other home countries.

PUBLIC HEALTH

The bill provides the underpinnings for public health in England with new body to drive improvements in the people’s health and gives local authorities a renewed role ( a role authorities had until 1974 until local government and NHS reorganisation).

At the local level local authorities will have a stronger role in shaping services and will take over responsibilities for local population health improvement. New Health and Wellbeing Boards will bring together local commissioners of health and social care, elected representatives and representatives of Health Watch to agree and integrated way to improve health and well being.

KEY LEGISLATIVE CHANGES

The Secretary of State in England will:

Retain ultimate accountability for the NHS

Have a new duty to take steps to protect the health of the people and a continuing commitment to the founding principles of the NHS

A duty to secure improvement in the quality of services

Have regard to the need to reduce health inequalities across the life course and across the social determinants of health that shape people’s lives and a duty enshrined in legislation for the first time on the Secretary of State, the NHS Commissioning Board and commissioning groups to have regard to the need to reduce inequalities in the benefits that can be obtained from health services.

PUBLIC HEALTH ENGLAND

Public Health England’s (PHE) mission is to improve and protect health and well being of the population and reduce inequalities in health and well being outcomes. Its role is to invest effectively
in prevention, health promotion and health protection and meeting the needs of different groups in society. PHE will have three functions, delivery of services, leading for public health and support and development of specialists and the wider public health workforce. It will also be expected to partner worldwide to tackle health threats, foster innovation and draw on behavioural sciences.

PHE will also provide support for Local Government which expected to lead for public health improvement because of its population focus, is democratically accountable for health and well-being and is well placed to tackle the wider determinants of health and pull together the work done by the NHS, Social Care, Housing, environmental health leisure and transport services. The bill says that the Local Authority must appoint a Director of Public Health, will have a ring fenced budget and the Director of Public Health will be expected to publish an annual Report to chart progress of local programmes.

Local Authorities will be paid a new health premium against public health indicators e.g. fewer children under 5 will have tooth decay; people will weigh less; fewer 65 will suffer falls; fewer people will smoke. Some of the outcome measures will be related to causes of ill health such as school attendances, domestic abuse and homelessness. These measures will sit alongside the Public Health Responsibility Deals between partners including the business community, voluntary sector and NGO’s which are to help people achieve a healthier diet, increase levels of physical activity, drink sensibly and understand health risks. The Coalition Government are also promoting the concept of the ‘Big Society’ - a smaller state with individuals and communities taking greater responsibility and want to use ‘nudge theory’ to effect behaviour change and public health improvement. Experts have shown that nudge theory can only work alongside other measures such as regulation. Professor Richard Parish, Royal Society of Public Health, claims “that it could be an excuse for Government not doing things by other measures alongside behaviour change.”

The details of the operating framework as well as public health outcomes and the ring fenced budgets were published at the turn of the year and staffs are being appointed for the new structures subject to legislation.

On balance the public health proposals, though opposed by the faculty of Public Health along with other health and medical professional groups should be welcomed. The ambition to tackle worsening inequalities, for local authorities, for the first time since 1974, to have responsibility for public health, must be right. To address the issue of independence the Government has clarified the arrangements for PHE as a Next Steps Agency to ensure its advice is seen as independent of Ministers. However concerns remain that new PHE will be seen as too close to government and public health professionals fear a less integrated approach because the public health budget will be held separately from the clinical budgets.

COALITION COUNTS THE COST OF THE HEALTH BILL AS IT HIT THE FINAL LAP

One of the major hurdles for the bill has been to convince legislators, professionals that the NHS does not become a US style market. On Monday 5th the Secretary of State signalled his willingness to accommodate such concerns. So where are we at on key issues of competition?

The ambition was to stimulate the market for NHS funded care by promoting competition between providers. This reflects body of academic evidence and political views about comparative
performance in the other home countries of the UK which suggests efficiency improves when hospitals compete. Some of the changes made to Monitor –the beefed up sector regulator –was changed after the Lib-Democrats imposed pause and gone was its remit to ‘promote competition’ and replaced with a duty merely to prevent anti competitive behaviour. Some of the outstanding concerns opponents of the bill say is that it still opens the way to US style marketisation, removes the role of the Competition Commission in assessing the NHS market and hospitals can still earn up to 49% from private patient income.

IS THE PAST AND LOOKING ELSEWHERE ANY GUIDE TO SHAPING THE FUTURE?

1 In England the lessons of the WHO workshop of 2001 were not learnt.

Technically the Health and Social Care Bill was sound in the main particularly the orientation to public health, the health inequalities agenda and new responsibilities on the Secretary of State to protect heath and giving back local government responsibility for public health coupled with well being. It failed however in the ‘process of policy making’. The Coalition Government following the Liberal –Democrats Annual Conference a year ago and strong party opposition to the NHS reforms, had to have – a pause and a listening exercise even as legislation was under way through parliament; as the bill went through its final legislative journey it encountered further negative support at the Liberal Party Conference. The bill also encountered very public professional opposition including from GP’s the very professional group that for the healthcare reform, that should have ownership for implementation. The general political context was difficult enough an austerity programme, welfare reform, departmental budget cuts, rising unemployment, global economic slowdown, euro-zone crisis without an own goal and what many have called David Cameron’s poll tax! The bill has now made the statute book but it will be very different from what was introduced and colleagues in the House of Lords will congratulate themselves on improving on the original particularly the Lib-Dems peers!

2 Ministries of Finance will drive the health agenda?

Since the Wanless Review of health care costs the UK Treasury has recognised the economic burden of chronic disease, social inequalities and the determinants of health and how they will place overwhelming burdens- to breaking point if rising healthcare costs are not contained by and active health promotion and prevention programme. The UK Treasury which was supportive of the Wanless ‘fully engaged scenario’ will continue to press the Health Departments through public service agreements, to refocus beyond health care. No doubt other government ministries of finance will do likewise.

3 Legislation and related regulations are often forgotten as instruments of irrevocable social change.

England’s reform health and social care legislation with a prominent place for public health- health improvement, promotion, disease prevention, health protection and tackling health inequalities- is such an instrument .It has been a long time coming given the Black Report and others before and since have argued for a refocus of the health agenda towards inequalities and the social determinants agenda.

4 It is essential to look and globally
Globalisation has shown us in the UK that the traditional preoccupation by governments to control their healthcare systems did not recognise that they had ceded control of the determinants of health to multinational corporations. Lessons from the past, such as with tobacco control which needed support from ministries of foreign affairs and trade in particular, point to the need for action to deal with NCD’s at all levels: Global: following the UN General Assembly in September 2011; Regional in the UK EU; the UK level as well as within the home countries and locally. In its operating framework for the new public health service, working with expert partners worldwide is a welcome recognition by the UK Governments.

5 Is the machinery of government fit for purpose and what can be learnt from elsewhere?

The challenge in the UK looking in recent years is whether the machinery of government is fit for purpose as its challenged by four health policies, coalition government, different political ideologies in Scotland, Northern Ireland, Wales, England and which are likely to become more critical as the referendum debate gets under way in the UK. A more Federal approach or some of the machinery of government in Australia including agencies such as A.I.H.W would be worth thinking through for lessons to be learnt. One of the proposals in the Nuffield Trust on devolution the end of the national health based on experience in Australia was the need for policy villages in the different jurisdictions.

6 Is there a political price for a focus on public health?

Drawing on experience from Wales I would contend yes because the gains are long term. I would contend that the labour government’s health policies which were built on public health programmes of some years standing in Wales, lost the election at the 3rd term because of insufficient attention to the healthcare and for which it was punished by the electorate. Also when the budgets get tight there is attraction to move from investments which have a longer term payback for those which are manifest to the public. In 2007 the IWA published the proceeding of a conference ‘The Welsh Health Battleground’ which described the tension between the demands of the immediate tactic battle in comparison to the campaign strategy. Hopefully the ring fenced public health budget in England will deal with this threat.

Lessons from the 1990 reforms where in Wales we were aiming to combine a public health agenda and a healthcare agenda it was important to maintain the right balance between the public health and healthcare agenda. It was also essential to ensure that those involved in implementation did not confuse the agenda. In the 1980’s The Griffiths reforms, which introduced general management were often misinterpreted in England as making the NHS a business. In Wales I interpreted the policy as making the NHS more businesslike promoting systems thinking – health, healthcare and learning, with a futures perspective focussing on health gain - years to life and life to years, people centred services and resource effective.

SUMMARY

In this talk I have described a rapidly changing health and health care scene in the UK in part responding to the global economic crisis, changes in the constitution of the UK, the emergence of 4 national health policies including tackling the social determinants of health, and a Treasury concerned about the unaffordable impact of NCD’s an aging population, promoting ‘good health as good economics’ and a focus on health outcome. This is all good news for the future of disease.
prevention and promotion, improvement and protection of health and now a challenge for the research and professionals to deliver lasting change for the public good.

John Wyn Owen

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