

viewpoint

The view from
Westminster:
Parliamentarians on
the future of health
and social care

In late 2012, The King's Fund and the Nuffield Trust hosted a series of round-table discussions with UK parliamentarians and health leaders. The series provided a platform for leading politicians and health leaders to explore the key challenges and opportunities facing health and social care, and how these can be met. A cross-party group of politicians took part in the seminars and several of the contributors have followed up their presentations by providing essays for this publication. We are grateful to them and in particular to Baroness Williams, who was instrumental in shaping this initiative. The views expressed are the authors' own, and do not necessarily represent those of either the Nuffield Trust or The King's Fund.

The **Nuffield Trust** is an authoritative and independent source of evidence-based research and policy analysis for improving health care. Our vision is to provide objective research and analysis that boosts the quality of health policy and practice, and ultimately improves the health and health care of people in the UK.

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About this publication

In November and December 2012, The King's Fund and the Nuffield Trust held a series of events in Parliament, to look beyond recent reforms and discuss the next wave of challenges facing the health and social care system.

The debate at each event was driven by parliamentarians; with a cross-party panel of MPs and peers alongside representatives from both the hosting organisations and clinical experts (Professor Tim Evans, Mr Leslie Hamilton and Dr Nav Chana respectively). The audience included a range of MPs and peers, together with professional and patient representatives.

The first event, chaired by Lord Hunt OBE alongside Dr Sarah Wollaston MP and the Rt Hon. Paul Burstow MP, looked at the overall financial, demographic and other pressures facing health and social care, and how the system might adapt to respond to them.

The second, chaired by the Rt Hon. Stephen Dorrell MP with Dr John Pugh MP and Lord Warner, looked at the case for redesigned hospital services and the implications of reorganisation.

A final event, chaired by Baroness Neuberger DBE with the Rt Hon. John Healey MP and Dr Phillip Lee MP, discussed how general practice, community services and social care would need to adapt to the changing needs of patients.

This Viewpoint features personal reflections by eight of the parliamentary speakers, based on their speeches and observations at the events. They offer a range of views and perspectives, united by a commitment to see Westminster play its part in resolving some of the most challenging issues in health and social care.

We are grateful to all those who participated in the seminars and contributed to this publication. In particular we would like to thank all those who chaired the events and Baroness Williams, who was instrumental in shaping this initiative and has kindly written the foreword.

Foreword: Rt Hon. Baroness Williams of Crosby



Baroness Williams is a Liberal Democrat peer and former Cabinet minister.

During the passage of the Health and Social Care Act, we in Parliament spent a long time discussing the structure of the NHS and the introduction of clinical commissioning groups. But many of the issues raised also reached into some of the deepest questions about our health service.

How can we deal with the growing gap between funding and the demand for care, not just over the course of years, but over the course of decades? What is the role of competition and private provision? What is the future for our unique system of primary care? Could moving care out of hospitals make the NHS work better for patients, as well as save substantial sums of money, and would politicians enable it to happen?

As the Health and Social Care Bill passed into law, I felt there was a need for continued deep engagement on the part of parliamentarians to address these issues; believing that well-informed MPs and peers from all parties could play a role in leading the public debate we must have, and working together to make a success of the new NHS.

The series of seminars, hosted by the Nuffield Trust and The King's Fund, from which this collection of short essays springs, was organised with the aim of providing a forum to bring together a range of political views on health and social care. This was done with an eye not to a particular piece of legislation, but to the broader issues facing us. I believe they succeeded in this, and I am most grateful to both organisations.

This publication contains articles by eight of the speakers we heard, written in the spirit of these debates. Some of them reflect on what they took away from the events; others look to set their views in a broader context, given all that has happened since then. All of them show a determination to improve health and social care, and a belief that it can be done.

Parliamentarians will never reach a full consensus on the best way to fund and provide care. Indeed, they cannot if they are to fully represent a public who care so passionately about these issues. But with an open-minded debate, and with trust in the genuine commitment of our colleagues, I believe we can play an important role in meeting the challenges facing health and social care.

Rt Hon. Paul Burstow MP



The Rt Hon. Paul Burstow is the Liberal Democrat Member of Parliament for Sutton and Cheam and is currently Chair of the Parliamentary Party. He recently served as Minister of State for Care Services.

Mr Burstow spoke at the first event, addressing the overall challenges facing health and social care.

The future of our care system lies in preventing or postponing people from needing care in the first place.

My ‘Care and Support’ White Paper was designed to do this. It proposed a radical shift in policy and practice, from a system that stutters into life only once crisis has arrived, to one focused on wellbeing, prevention and early intervention.

The challenge facing health and social care is not just how we support the growing number of people with co-morbidities. It is how we tackle the causes, the wider determinants of health and wellbeing. This convergence between public health, social work and health is the really exciting opportunity for the future.

Our current systems are predicated on perverse incentives: people have to prove dependence and refuse informal help to qualify for services. We need to work with the strengths of people and communities to foster resilience, reciprocity and support self-care.

We should ask what people can do for themselves, rather than what we can do for them. Older people must be encouraged to have a proper stake in their communities so that they can lead the lives they wish to. Such a revolutionary idea can only become reality with a change in culture, and with careful use of the levers which can make it happen.

This leads us, unavoidably, to the challenge of funding. According to the RSA Action and Research Centre’s *Plugging the Gap* report, there is a social care funding gap of about £634 million a year. While exact figures can be disputed, it would be churlish to deny that local authorities are having to make brave decisions about how they commission and deliver services.

It is encouraging that some are already coping with this by being innovative in how they deliver services. A budget survey from the Association of Directors of Adult Social Services revealed that for every £1 councils saved in 2011, 69 pence came through greater efficiency. Last year that figure rose to 77 pence.

Yet all too often, budgets are still set in silos. For example, a handrail in an elderly person’s house costs £30 – but a hospital admission for a fall costs hundreds. It is common sense to invest

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to save, but without more pooled and community budgets the incentives to do so simply do not exist.

In 2002, the Treasury asked the late Sir Derek Wanless to review health spending. He recommended that work be done to understand better the financial interdependencies between health and care, calling for better financial models and a review of social care funding. At the time nothing came of this, but his recommendations remain valid. It is time the Treasury did this work, and helped to future proof our health and care system.

The question of funding is inseparable from the question of fairness. Who should pay for care and how much? Labour dropped the ball while in government, but the Coalition’s recent announcement on implementing Andrew Dilnot’s practical solution is a hugely positive step forward.

While the level of the cap is higher than many hoped for, the plans recognise for the first time the importance of protecting people from the sometimes catastrophic costs of care. Less commented on is the extension of the meanest of means tests. This extends state support to many more people with modest wealth and is an important recognition that social care matters to us all.

The devil will of course be in the detail of these changes, the mechanics of the metering system, the creation of care accounts and a national minimum eligibility threshold will all need careful scrutiny.

No, doing Dilnot won’t solve all of the challenges facing the care sector, under-funding first and foremost among them. But it certainly will be a big step in the right direction and a legacy for this government.

Rt Hon. Lord Hunt of Kings Heath OBE



Lord Hunt OBE is Deputy Leader of the Opposition in the House of Lords and a former health minister.

Lord Hunt spoke at the first of the events, addressing the overall challenges facing health and social care.

In the opening event of a fascinating series of breakfast debates hosted by The King's Fund and the Nuffield Trust, parliamentarians had an ideal opportunity to look at some of the longer-term challenges facing health and social care.

The last two years have seen endless debate about the proposals encompassed in the Health and Social Care Act. Under great financial pressure, the NHS has wasted time, effort and billions of pounds on unheralded and unwanted changes. It was clear to me throughout the debate that the Government's plans are largely irrelevant to the tremendous challenges the NHS faces in meeting growing demands, demographic pressures and the need for a much more integrated approach to the care of frail older people. Acute trusts are under huge pressure to reduce bed capacity in the naive assumption that beds are fuelling demand and encouraging patients to come to hospital. But the reality is that hospitals are often the one bit of the system that can be relied upon at all hours of the day and night.

Given the particular support required for frail older people, there is a pressing need for primary care and social services to step up to the plate. But the bizarre decision to hand over so much NHS money to GPs looks ever more questionable as they are clearly struggling to meet basic demands on their services. Sarah Wollaston spoke about many of the pressures faced as GPs take on additional commissioning responsibilities and have to explain rationing decisions to patients. Offering a view from acute care, Tim Evans of the Royal College of Physicians suggested primary care return to a seven-day week, and emphasised the importance of ensuring that general practice standards keep pace with the quality of specialist care.

Then there is the question of political vision. Paul Burstow worried about the lack of a compelling narrative and vision of what future health and social care services should look like, arguing that restructuring on its own would do little to achieve change. He argued that relationships should be more central to the organisation of care, and for funding models which would underpin that interdependence between health and social care.

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Both Jennifer Dixon from the Nuffield Trust and John Appleby from The King’s Fund acknowledged that the funding system could be improved to support the integration of services, and in particular the need for reform of both tariff and block contracts. Both agreed that competition was likely to result in only limited savings.

Many certainly agreed that restructuring on its own would do little to achieve change, and it was striking that our speakers strained the imagination to come up with ways in which the new architecture could be tempered to deliver better-integrated care. The challenges ahead are clear, and there is agreement across the sector that closer collaboration and strong local leadership are the key ingredients needed to improve the system. It now falls to politicians to provide the long-term vision to make this a reality.

Dr John Pugh MP



John Pugh has been the Liberal Democrat Member of Parliament for Southport since 2001, and is co-Chair of his party's Parliamentary Policy Committee on Health and Social Care.

Dr Pugh spoke at the second of the events, addressing the case for change in hospital services.

Clinicians and health service administrators can often identify ways of reconfiguring services, particularly hospital services. These reconfigurations usually appear to deliver improved outcomes but prove hard to sell to a sceptical public.

On these occasions, local politicians are urged to be brave and support such moves. All too often though, the politician is found fanning the flames of popular discontent and those inside the NHS look upon them with varying degrees of sympathy, bewilderment, despair or contempt. The situation is actually made worse if health insiders believe that politicians privately understand the case for change but publicly resist it.

Politicians have a primitive instinct for survival and from Kidderminster to all places north, south, east and west they know that there is no future for an MP or councillor who fails to respond to public alarm about hospital services. Bravery is one thing; foolhardiness is another. Anyone who has felt the heat of a 'save our hospital' public meeting can testify to this.

Even if the politician is prepared to be 'brave', he will soon have potent rivals who will damn his bravery as supine acquiescence.

Clinicians, on the other hand, are generally not up for or used to rough questioning from the general public. It is naive anyway to suppose that local clinical opinion is unanimous; it rarely is – which leaves 'brave' politicians still more exposed.

To understand all of this properly, the focus should not be on the behaviour of the politician but on the underlying dynamics. The public have a nose for financial or institutional pressures and can readily see that the good clinical case is not just a good clinical case. They also may not share the mindset of clinicians in the way that clinicians feel they should. They value proximity and access as well as quality of service, and are prepared to consider trade-offs between them.

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Nevertheless, I don’t think the public are quite as unreasonable as clinicians and hospital chiefs often suppose. They will travel to the ends of the earth to get life-saving treatment and high-quality intervention, but they sensibly see no need to travel far for basic triage or first-base treatment. They carry around in their heads a notional idea of the distance they must travel for medical reassurance.

In my constituency, cancer patients travelled without complaint right across Merseyside to the Wirral. Yet the town was outraged when a reconfiguration meant that children suffering accidents had to be triaged just eight miles away in the next town.

Clinicians have no such maps in their heads. They tend not to use local buses and regard roads as a purely council matter. They know roads can be a problem – but not an NHS problem.

Until the NHS comes to terms with access and expectations of access, and is prepared to listen to the voice of the public on this issue, plans hatched will tend to be scotched by public opinion. There won’t be the political will to see them through. And, arguably, there shouldn’t be.

Rt Hon. Lord Warner



Lord Warner is a Labour peer. He has served as Minister of State for Health, and as a member of the Dilnot Commission on Funding of Care and Support.

Lord Warner spoke at the second of the events, addressing the case for change in hospital services.

In an age of austerity, there is increased recognition that even the NHS faces growing financial pressures over coming years. But many, including some who work around the service, still do not fully appreciate the scale of what lies ahead.

We must deal not just with the Nicholson challenge up to 2015, but with an unprecedented spending test extending far into the foreseeable future. A report by the Nuffield Trust in December 2012, *A Decade of Austerity?*, found that, without unprecedented increases in productivity, NHS funding in England would need to increase in real terms between 2015 and 2022 simply to maintain current standards of service and quality of care.

But such a real-term funding increase looks increasingly unlikely, so service leaders will need to be dogged in pursuit of efficiency savings. As things currently stand, a full decade of pay austerity would be needed to make a dent in the four per cent efficiencies required. Improved choice and competition for service users, a central aspiration of governments during the last decade, would also suffer due to diminished capacity.

We must also ask tough questions about taxation and wider spending. A January 2013 report by The King's Fund, *Spending on Health and Social Care over the Next 50 Years*, found that, if left unchecked, growing demand for health and social care services would translate into around half of public spending in 2061. An honest and informed debate is needed about where public priorities lie.

Similarly, there must be frank discussions about the configuration of hospital services, which are often set up in a way that no longer suits their main purpose. The role of the NHS has been evolving since its establishment: an ageing population and changing burden of disease mean that increasingly its core business is treating people with long-term conditions. But too often patients lie in hospital beds when their conditions could be better treated in community and social care, at as little as one third of the cost.

So why do we not set a target for moving £10 billion of spending out of acute care, and into the development of better integrated care, prevention and care closer to home?

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There are too many district general hospitals pretending they can maintain an equally effective service across A&E and other multiple specialties. We need a fundamental rethink of where acute services are located, with specialist services concentrated on fewer sites to allow a better balance between choice and access on the one hand, and consistently high-quality care on the other. This may mean, for example, accepting that we only need 170 maternity units nationally. Local closures are never popular, but this is the scale of change we must consider.

Primary and community services cannot avoid reform. Indeed, there is a strong case that they should be driving the process, and politicians should use the GP contract as a potentially very powerful lever to improve patient care and experience. But overall, we must reduce significantly the excessive number of hospitals trying to cover every speciality, using the savings to boost primary and community care, and to prevent a collapse in social care funding. The crucial challenge for politicians will be to agree a cross-party mechanism to bring about such changes.

Rt Hon. Stephen Dorrell MP



The Rt Hon. Stephen Dorrell is Conservative Member of Parliament for Charnwood. He is Chairman of the House of Commons Health Select Committee, and has formerly served as Secretary of State for Health.

Mr Dorrell chaired the second of the events, addressing the case for change in hospitals.

The litany of challenges facing hospitals is by now familiar: rising demand, spending restraint, making the best use of new technologies, and finding ways to adjust the acute sector to a world of chronic illness.

A service that has struggled to make progress on productivity for decades now faces a future in which there will be no alternative but to make steady efficiency improvements, year-on-year, while at the same time maintaining a level of quality upon which vulnerable people depend.

The task is daunting, but I remain an optimist. I believe we increasingly understand what needs to be done, and that the willpower needed to do it is gradually building.

If a single number tells us where we should look first, it is the National Audit Office's finding that 30 per cent of all non-emergency admissions are avoidable. If we do not make sure our care services work together to address this, this figure will grow steadily as our ageing population sees chronic illness and multiple morbidities account for a rapidly increasing proportion of caseloads. Accepting this status quo is not an option.

We must view this change in what hospitals do as an opportunity, not a problem. We can't heal a broken leg or a sudden bout of flu before they happen; but we can ensure that people with diabetes or chronic pulmonary disorder are dealt with as soon as their condition begins to worsen, and that they and their families are able to manage their conditions to the best of their abilities. We need to build more exit points on the path that leads patients to hospital, and we need to reconfigure hospitals themselves to optimise efficiency and quality.

Fifty years ago, Enoch Powell struggled to move patients out from the massive asylums that dotted British cities into flexible, local community care systems which could deal with them as individuals. He spoke of hospitals as "shells" for the care that goes on inside them, and warned against the danger of forming an attachment to them rather than to the purposes for which they were built. I believe we face a similar challenge today.

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Powell suggested that it was from the professions that he feared resistance to change. But I see many people in the NHS who would embrace reconfiguration that allowed them to spend more time working where they could do most good. Perhaps a greater problem is an understandable fear of changes to local hospital arrangements among those who rely on their services. Politicians of all parties owe it to the public to have an honest dialogue here, rather than trying to exploit confrontations for short-term political gain.

This is not to say that reform will always mean closures or consolidation. New technologies like smartphones and telecare are making it easier than ever before for consultants’ expertise to be brought into homes and GP surgeries. In future, the cost of communication will only fall further and we must be ready to ensure that we take full advantage of the flexibility this brings.

The Secretary of State’s decision earlier this year on the reconfiguration of Lewisham hospital was based on a clear assessment of clinical need and a willingness to risk political difficulties. It was a promising precedent, but the time for precedents is passing.

Our mindset needs to be one that accepts the need for ongoing reform. For everyone responsible for hospitals – politicians, managers, clinicians and the public – innovation and change should be seen not as an interruption, but as part of the day job.

Dr Phillip Lee MP



Dr Phillip Lee is the Conservative Member of Parliament for Bracknell, and a practising GP.

Dr Lee spoke at the final event, focusing on the future of primary and community care.

If we stand back now, the NHS may tip over the edge of its own 'fiscal cliff'. Future health care services face serious challenges such as changing demographics (particularly aging), increasing obesity levels, and rising costs of new treatments and medicine. To do nothing about the increasing demands being placed upon the system would be a political mistake.

I believe that the current infrastructure, and the widespread and relatively unchallenged acceptance of a service funded solely by the taxpayer, will lead to poorer patient outcomes than we should be achieving. We have no choice but to fundamentally change the way this country's health care is funded and delivered in the 21st century.

As a politician and a medical professional, I am constantly battling with the challenges facing the NHS. There is a real need for consolidation of hospital acute services, to release funds which can help to improve the quality and performance of community care. Furthermore, I strongly believe and have argued on several occasions that health care costs, driven upwards by the inexorable increase in patient demand, have now reached a tipping point.

Any politician who thinks that the current NHS financing model and physical structure can be sustained in the medium to longer term is deluding themselves. By doing so, they are exacerbating the trust problem that all politicians currently have with an increasingly cynical public. It is time that politicians told the truth about the NHS: that the reality of health care provision in Britain today has changed, and will change even further over the coming decade. It is time to engage in an informed debate with the British public and then take the required action to save our universal health care service before it is too late.

As a GP, I have seen over 50,000 patients, and I am struck by the stark differences in behaviour developing between the generations. The stoic attitude of the post-war generation is significantly different from that of people born more recently. Behaviour has an impact on the conditions I deal with: when baby boomers hit their eighties after 2025, around 25 per cent of the NHS budget will already be spent on diabetes alone.

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Without doubt, in future an increasing number of people will be getting prescription medication for conditions related to lifestyle choices. According to the NHS, over 886 million prescriptions were dispensed in England in 2009 at a cost of over £8.5 billion, a figure that is set to increase. This is why we have to make some tough decisions about future funding now, to ensure that the chronic and terminally ill patients of the future have the care that they need. As the 22 per cent of the British population born between 1945 and 1960 start drawing their pensions over the next few years, there is a real danger that the resulting costs will exclude younger generations from access to an NHS free at the point of use.

For our health service to be efficient and effective during these economically challenging times, responsibility for health care funding should be moving slowly away from the state towards the individual. We also need to restructure our acute health care services, which will require district general hospital closures, consolidation of acute specialist services into larger, new ‘hub’ hospitals, and the building of new community clinics.

Changing the public’s mindset on these issues will be extremely painful politically, with no short-term reward – but we have no choice if we are to protect the fundamental principle of access for all. I want people to be free to choose any lifestyle they wish, while understanding its future health care cost implications. I want to give more to the truly deserving because we have spent less on those who were perfectly able to provide for themselves. I want the very best 21st-century health care to be delivered in safe and appropriate environments. If we do not persuade the public of the need for these changes, it is the truly vulnerable in our society who will be placed at risk.

Rt Hon. John Healey MP



The Rt Hon. John Healey has been the Labour Member of Parliament for Wentworth and Dearne since 1997. He has previously served as Shadow Secretary of State for Health and as a minister at HM Treasury.

Mr Healey spoke at the final event, focusing on the future of primary and community care.

We know what is needed in our health and care services. There is a broad consensus behind the case for shifting services away from last-minute crisis intervention in hospitals towards early intervention, preventative treatment, and care and support that is community-based.

We already have good examples of successful innovation and radical change at every level – nationally with cancer care, regionally in London with stroke services, and locally in almost every area, as in Rotherham where diabetes diagnosis, management and support is now led by specialist nurses outside the hospital environment.

Such experience suggests certain common conditions for successful change. I would single out strong leadership, with clinicians out front; strong evidence, especially on better care for patients; and strong strategic commissioning with the five key hallmarks of collaboration, innovation, integration, localisation and sanction for failure (including decommissioning).

But I believe the change needed in the NHS is more fundamental than anything the professional policy debate has so far allowed us to discuss. So what are the axes of the far-reaching reform that is required?

First, primary and community services must be as much a focus for attention as hospitals. After all, four out of five consultations for patients already take place outside hospitals.

Second, primary care services must be as ready for exacting challenge as the rest of the NHS. They have been largely cosseted from the changes driven by the government's wholesale NHS reorganisation, yet variation in standards remains wider, and public accountability weaker, than in any other part of the NHS.

Third, the way in which treatment and care is delivered must be as much a concern as the way in which it is organised. The patient must be uncompromisingly at the centre.

Fourth, managing demand must be as much of a priority as managing provision. This requires fresh financial arrangements such as full budget sharing for all health and care services in a local area, or year-of-care payments per patient.

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Fifth, the creation of a single point of access to coordinated health and social care, especially for older and disabled patients, must be given as much attention as the creation of single-patient records and IT systems.

Such cultural and operational change takes constant pressure, and years of consistent effort, to put fully in place. It is best done with a broad public, professional and political consensus behind it. Achieving this, unfortunately, has been made much harder by the Coalition Government’s NHS reorganisation and legislation.

The Health and Social Care Act means the necessary collaboration and integration at the heart of these NHS changes are now much more constrained, and will in time be legally challengeable. The Act has also made the NHS a major political battleground, because of both the misjudgement in overriding manifesto and Coalition Agreement pledges, and the market ideology which runs through the legislation like a stick of rock.

What happens in the NHS over the next two years may help determine the winner of the next general election. In the meantime, I fear patients will be the losers.

Baroness Neuberger DBE



Baroness Neuberger DBE is a Crossbench peer. She has been an advisor to government, and is a former Chief Executive of The King's Fund.

Baroness Neuberger chaired the final event, focusing on the future of primary and community care.

The challenges facing primary and community care reflect the challenges facing our health and social care system as a whole. Tightening funding, increasing demand and, in the face of these, the vital need to protect and enhance the dignity and compassion which should be at the core of all health and social care services.

Of course, primary care faces challenges of its own. But it is in general practice surgeries that the vast majority of interactions between the public and the health service take place – more than 90 per cent of all contact – and where abstract national challenges meet the reality of those who need care.

During our discussion, Phillip Lee argued that if we are to cope with the challenges of funding and demographic change, patients must have incentives to exercise self-management – to take preventive care and routine testing into their own hands. But we risk undermining the ethos of care and placing unacceptable burdens on vulnerable people when we dictate self-management from on high. It must emerge from a system which is built to accept autonomy, choice and dignity for all who use our services. This means making sure patients have a say in where they are treated and that care supports, rather than interrupts, their personal lives.

All too often, growing numbers of people with long-term conditions find themselves pushed into roles defined by institutional structures: primary care patient, outpatient, inpatient, social care user. This model suits neither patients, nor professionals trying to provide care where it can do most good.

We need to look at training and investment if we want to empower primary care professionals to change this and help move care closer to patients. As the entry point to the NHS, we should be seriously concerned that GPs are not receiving training or guidance on how they can create integrated care pathways. Community nurses are one of the most flexible parts of the NHS and already work with patients across health and social care. Yet the Royal College of Nursing warns that we are moving towards a workforce crisis. The average age of a community nurse is rising fast; and the number of community nurses continues to fall as unplanned hospital admissions soar.

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The experience of integrated care led by Trafford Primary Care Trust is often pointed to as a pathfinder for efforts to create integrated, patient-centred care. A key principle from the start was that general practice should be the ‘locus of integrated services’. Access to population data and experience working with community hospitals allowed GPs and nursing teams to draw up pathways that ensured patients were treated close to home. A system of named specialists and consultants supporting GPs allowed them to work with patients to decide where in the health and social care system their needs could be best met.

We cannot force a single model of integration on diverse local communities. But we can do much more to give leaders in primary care the confidence to find new ways of connecting care around patients. This will be an important step towards what must always remain our ultimate goal – giving patients the dignity and the tools they need to take ownership of their own lives and their own care.

Afterword: Jennifer Dixon and Chris Ham CBE



Dr Jennifer Dixon is Chief Executive of the Nuffield Trust.



Professor Chris Ham CBE is Chief Executive of The King's Fund.

Political consensus on a subject as complex and emotive as the health service can be hard to find, as the recent debate on the Government's health reforms reminded us. But the seminars which inspired this publication have proved to be a heartening experience; with the politicians who contributed their time all showing a willingness to engage in informed debate about the crucial issues facing health and care.

The NHS finds itself confronted by a 'triple demand challenge' of demographic pressures, a changing burden of disease, and rising patient and public expectations. Technologies too are evolving rapidly and are changing the way patients are able, and expect, to interact with their health care providers. Yet care is still often delivered in ways designed for a very different era. Too much of it is provided in institutions, while prevention still comes a poor second to treatment. The traditional boundaries separating GPs and hospital-based specialists, hospital and community-based services, and mental and physical health services endure – care often lacks necessary integration.

Incremental changes to the existing system will not be enough. A much bolder approach is needed, to bring about innovative models of care which meet changing patient needs and provide services that are high-quality, sustainable and offer value for money. Fostering such new models of care will mean supporting local NHS organisations to innovate and adopt good practice, and to test new and imaginative models of care. Crucially, it also means identifying what is working and what is not through rigorous evaluation. The professions too will need to adapt; the present system relies too heavily on individual expertise, where patients and users often want to play a more active role in their care and treatment.

During the seminars, there was a striking consensus that primary care will be central in meeting the challenges of the future. Despite a historical emphasis on hospitals as the starting point of service redesign (and the main recipient of NHS spending), patients have to navigate a whole system within which primary care plays an increasingly crucial role. While it faces its own challenges, there are

positive stories too, as new working practices and technology make it possible to manage chronic conditions more effectively closer to home.

Underlying the visible challenges from rising demand, there are of course major financial considerations. An immediate focus on NHS productivity must not conceal an uncomfortable truth – that health and social care will need to make unprecedented efficiency savings, not just for the rest of this parliament, but for the rest of the decade. It is here that common ground may be harder to find.

As in many other countries, health spending continues to absorb an ever higher proportion of national wealth in the UK. Increases are not inevitable, but there is a risk that the public do not fully appreciate the financial pressure the health service is under. An informed debate with the public on future spending and funding options, including an honest assessment of the difficult decisions and trade-offs implied, must surely begin.

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Nuffield Trust is an authoritative and independent source of evidence-based research and policy analysis for improving health care in the UK.

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