VINTAGE

NEW LIFE FOR HEALTH

WILL HUTTON

Contents

About the Book

The National Health Service is Britain’s greatest and most prized national institution. Ever since it’s foundation the NHS has commanded extraordinary popular affection and loyalty. Its medical and non-medical staff alike have been strongly committed to its success and values. However, now more than fifty years later, a huge gap has developed between what the NHS is able to deliver and the expectations and the needs of its users. The deterioration of the NHS dominates our news headlines today.

In 1999 the Association of Community Health Councils for England and Wales established a Commission, chaired by Will Hutton, to examine the issue of the public interest and accountability of the NHS. The Commission’s report has come up with some radical reforms that will transform the accountability of the NHS and will help rebuild the relationships between patients, and doctors and NHS staff, on a new basis of openness and trust.

About the Author

The Commission was set up in March 1999 by the Association of Community Health Councils for England and Wales (ACHCEW) in order independently to examine the issue of the public interest, and how it is served by the system of accountability in the NHS. A full list of the Commissioners appears in Annex 1.

Will Hutton was appointed chief executive of the Industrial Society in February 2000. He was previously editor-in-chief of the *Observer*, and is the author of many books, including the bestselling *The State We're In*.

NEW LIFE FOR HEALTH

The Commission on the NHS
chaired by Will Hutton

VINTAGE

Executive Summary

THE NHS IS Britain's greatest and most prized national institution. The 1946 Act that created it declared that its aim was 'to deliver free and equal access to comprehensive health care: not to this or that sectional interest, but to the requirements of the British public as a whole'. At one stroke the then Labour government created a milestone in relieving one of the keenest fears of the great majority of the British people – of being unable to afford proper health care – and in establishing the cornerstone of social citizenship in Britain. In 1951 ministers acknowledged that the NHS was 'the most popular of all our new institutions'.

More than fifty years later, the NHS retains its national mandate and its popularity. A special poll we commissioned to inform this report found that the great majority of people – nearly two-thirds (63 per cent) – regard the NHS as the 'most valuable institution' in this country, easily surpassing in public regard the runners-up: Parliament (12 per cent) and the police (11 per cent). (Only 3 per cent put the Royal Family first.)[1]

The NHS is tasked to provide equal care to every British citizen on the basis of their equal need, irrespective of where they live or how much they earn. The service is publicly owned and accountable, and is almost wholly financed by general taxation. Ever since its foundation it has commanded extraordinary popular affection and loyalty. Its medical and non-medical staff alike have been strongly committed to its success and values. Indeed they have been one of the NHS's strongest and most enduring assets.

However, a gap has opened up both between what the NHS is able to deliver and the expectations and needs of its

users, and between its original principles and current practice. The UK has slipped to almost the bottom of OECD countries with respect to public funding and levels of health service provision. The capacity of individual patients and local communities to secure the health care they want and expect, to win information about the reasons for decisions and to pursue complaints according to basic principles of natural justice are poor. By any standard – ranging from relief from cancer to long-term care and rehabilitation – Britain's system of public and clinical health care is unsatisfactory.

These trends have been clear for some time, but over the last five years there is growing evidence that they have now reached a critical point. Indeed it was the political impossibility of not responding to deeply felt public criticism that provoked the government into its announcement in the March 2000 Budget of a sustained and substantial increase in NHS spending over the next four years, along with the Prime Minister's earlier aspiration to lift British health spending to the EU average. The leading professional organisations within the NHS have become less restrained in their complaints about the standards of clinical care they are able to offer, the pressure on services and beds and the intractability of waiting lists. The poor pay and working conditions for NHS workers are greatly resented, and there are signs that the turnover rates among some categories of staff are dangerously high. The public is less willing to accept indifferent standards, the number of complaints is rising, and there is an ominous rise in the cumulative potential bill for medical negligence – on the latest figures close to £3 billion.

The ICM poll reveals considerable public concern about the service the NHS provides. Only 4 per cent of people think that the NHS provides a good service that cannot be improved, while a third agree that it 'basically provides a

good service' that could be improved in small ways. However nearly two-thirds believe that it requires to be improved 'quite a lot' (43 per cent) or that it delivers a poor service and 'needs a great deal of improvement' (19 per cent).

There are three main reasons for the disturbing deterioration in service. First, the NHS has been kept on short financial rations since its foundation, notwithstanding the overwhelming public support for the institution. Governments have sought to contain costs by redefining what the NHS provides, so eroding the principles of comprehensive care and services free at the point of delivery. There has been too little focus on benefits and an over-emphasis on cost control. A growing number of services – NHS dentistry, optical services, some routine elective care and the majority of long-term care services – can no longer be regarded as being provided universally, freely and equally. Individuals have increasingly been left to fund them themselves. Within the NHS rationing has spread together with inequity as the rationing criteria have varied between health authorities and health service providers. At the same time, due to underfunding, there has been a consistent inability to raise levels of care and treatment in line with the public's rise in living standards and its accompanying expectations.

In this respect the government's promise that NHS spending will rise by 6.1 per cent annually in real terms over the next four years is a welcome change of course, as is the aspiration to lift spending towards the EU average, although we note that even after the promised increase in spending it will still fall some way short of that aim. But for the first time since its foundation the chronic underfunding of the NHS is likely to be at least partially addressed. How that money is spent, however, and the manner in which the government is making reciprocal demands for NHS modernisation and improved outcomes, only increases the

urgency of addressing the other shortcomings that our report discusses.

The second reason is closely related to the first. Important inequalities have followed the introduction of the ‘internal market’, for paradoxically it was so poorly designed that it produced the disadvantages of markets with none of their advantages – even if those had been appropriate for the health service, which we doubt. Aiming to devolve decision-making and responsibility to promote efficient resource allocation, the new structure exacerbated inequalities through introducing market-based contracting between local NHS providers and fund- and non-fund-holding GPs and thus moving away from the principle of equity and community risk-sharing. The ‘internal market’ created winners and losers, among purchasers, providers and patients alike.

The current Labour government recognises these deficiencies, but its 1999 Health Act only partially addresses the problem because the new system of commissioning promises to reproduce some of the damaging fragmentation caused by the ‘internal market’. The financing of new replacement hospital construction through the Private Finance Initiative (PFI) has tended to reduce bed numbers and clinical staff budgets by up to 30 and 25 per cent respectively in the areas to be served by newly constructed PFI hospitals. Care and clinical priorities are now explicitly traded off against economic goals, including returns to private shareholders.

Primary care has long been the Achilles heel of the NHS. Unlike the rest of the medical profession GPs retained their independent contractor status after 1948, but despite being entirely dependent on public funds, structures to ensure direct public accountability at local level have been lacking. The new Primary Care Groups (PCGs) and Primary Care Trusts (PCTs), which are to run integrated, unified budgets for the total health care in local areas, do little to reduce

the accountability deficit, even though one of their purported aims is to delegate decision-making to local level, and ultimately PCTs will have a majority of lay persons on their boards. The establishment of the National Institute for Clinical Excellence (NICE) and the Commission for Health Improvement (CHI) is meant to level up varying standards in clinical treatment and to ensure that local health policies correspond to best practice. But they are superimposed upon structures and systems that at least in part pull in the opposite direction.

The third reason for the shortfall in service is that the doctrine of ministerial accountability has disguised a wider absence of accountability and transparency of decision-making within NHS structures. The Commission is concerned that the government and NHS are not accountable enough across the gamut of decision-making on health care – from the overall level of funding and planning of services, to the redress of individual patients' grievances and the say they have in their medical treatment. More than half the public (55 per cent) believe that patients should have 'a lot of power' over the medical treatment they receive, and a further 39 per cent that they should have 'a little power'. But only one in five people (20 per cent) actually believe that they have a lot of power over the treatment they receive and as many say they have no power at all. About half think they have 'a little power'. So although doctors and medical staff increasingly attempt to consult and inform their patients, there is clearly room for a more empowering ethos in the NHS.

The absence of accountability has coincided with the increasing insistence, in all walks of British life, on more accountability, more information and higher standards in decision-making and subsequent execution. The NHS is inevitably exposed to the full force of these developing trends. The government is seeking to address such new demands from the public by calling for improved

professional regulation, establishing NICE and CHI, and adherence to the Patients Charter. NHS Direct and walk-in centres are also part of an attempt to recognise that citizens are becoming more active consumers of health, as the NHS Alliance put it their discussion paper published in March.[2] But these initiatives cannot close the accountability deficit.

In the absence of adequate, strong democratic structures the public is using the NHS's undeveloped complaint mechanisms or even the courts to seek redress of grievances – a development that is bound to grow further when the 1998 Human Rights Act becomes operational in autumn this year. Together these trends raise the risk that litigants could exercise a disproportionate influence over policy and could undermine the capacity for rational, collective decision-making that ought to be at the heart of the NHS.

The Commission is alarmed that the Prime Minister's strategy for driving improvements through the NHS is highly centralised. Incorporating small appointed task forces at the centre will compound the inherent weaknesses of the service. The NHS is too large and complex an institution to be controlled effectively from the centre, with even the outgoing chief executive, Alan Langlands, conceding that the control of the NHS has foundered on an over-reliance on the contractual relationship between health authorities and trusts that obliges the NHS Executive's regional offices to adopt a hands-off approach. There is an urgent need for more local accountability rather than yet more administrative fiats from the top. A democratic voice and accountability must be deployed as buttresses against inequality and inefficiency of provision. In our view, democratic accountability at all levels of the service will be a more effective means of supplying the discipline that the Prime Minister is seeking to impose at and from the top.

For the chief route in a democracy towards closing what amounts to a gap in trust between the public, the government and the NHS is to promote the accountability of this great institution and thereby secure its legitimacy. The more the public are directly involved in running the NHS, even in electing its decision-makers, the more accountable the NHS will become, and the more the public's sense of ownership and its legitimacy will grow. The public will then share in the crucial decisions over funding, both nationally and locally.

The public must mean all of the public, including women, people with disabilities and the ethnic minority communities. In the wake of the Lawrence inquiry in which the government accepted that there is racism in all our institutions, we need to build an NHS that is explicitly committed to the promotion of equality: from its system of governance to how staff are recruited, developed, promoted and retained.

The poor levels of accountability within the NHS have been debated ever since its launch, but the issue has never been resolved. In general, under the tradition of ministerial responsibility, the secretary of state or minister responsible for health is made accountable to the public via the House of Commons. This approach has changed slightly with devolution, and in Scotland and Wales their own health ministers take a measure of responsibility, though overall health spending is still largely set by the Treasury. But, mainly due to the weakness of the House of Commons, the tradition of ministerial responsibility has long been shown to be incapable of delivering real accountability (see chapter 3).[3]

Over the NHS's history there have been a variety of regimes in which decision-making has been delegated to regional and local level, with a varying readiness to incorporate external voices and assert some degree of accountability, but no settled system has been established.

In addition there are ad hoc independent inquiries and review panels in response to individual problems and public concerns, and there is a complaints procedure for individual cases. But none are backed by a constitutionally entrenched framework of patient rights.

Over the past year, the Commission has considered how best to remedy the shortfalls in accountability, ranging from the overall decision-making apparatus of the service, its rationing processes and the role of the courts, to the work of health authorities and the new primary care groups at local level. At present there is only one formal mechanism for giving voice to the concerns of patients and families – the 206 Community Health Councils (CHCs) in England and Wales and the 16 Local Health Councils in Scotland (Northern Ireland has four health and social services councils). The CHCs and their Scottish equivalents act as formal watchdogs and represent patients' interests. Recent structural changes have removed the regional health authorities and downgraded the district health authorities with which CHCs and Scottish Health Boards and local councils have had a statutory monitoring role and rights to be consulted.

In the Commission's view, the overall system of accountability in the NHS is unacceptably weak. It is perhaps the least accountable of Britain's major public institutions, even though access to health is the prime concern of British citizens. This democratic deficit in the NHS has been widened by recent changes to its structure and is likely to widen still further as the next round of structural change takes effect and the highly centralised strategy to raise standards commences. We have come to agree with the Select Committee on Health, which in autumn 1999 argued that the NHS needed to transform an ethos that is too defensive, inward-looking, and locked in a blame culture.[4] However, the scale of this change means more than new ministerial initiatives, new quangos and

task forces, cosmetic additions to practice and regulation and more codes and charters, all lubricated by more cash. Something more fundamental is required.

As we have seen, the NHS is a highly valued national institution. In our poll the public also showed a remarkable attachment to its basic founding principle – the idea that people should have access to ‘free medical treatment at the time of need’. The people polled agreed almost unanimously (96 per cent) that this should become a right under a British Bill of Rights, ranking this right to free medical treatment at the time of need with other basic human rights, such as those of free speech, fair jury trial and privacy. Thus our chief recommendation is that the government should consult the public over writing a constitution for the NHS to ensure that this founding principle is protected in practice by the government and NHS. This constitution should represent the shared principles and values to which the public, all political parties and NHS constituencies subscribe. We also recommend that the government should establish the NHS as a national institution, independent of direct government control, and reform these structures to give practical shape to its constitutional independence.

There are models for such an arm’s-length institution, though they are less ambitious in scale and suffer some shortcomings. For example, the BBC is a public corporation with its own ‘constitution’ – that is, its royal charter. The Bank of England has been given independence with a remit set by government ministers. However the purpose of these arrangements in both cases is to offer these institutions some protection from government interference and to remove their operations from the daily round of Britain’s intense and confrontational party politics. Our aim should be to do better with the NHS.

We do not suggest that the NHS should or could become wholly independent of government and the political