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Future Challenges for the NHS

An International Perspective on the 50th Anniverary

Donald Light

Foreword by
John Wyn Owen

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ABOUT THE AUTHOR

Donald Light has carried out a number of commissioned studies for the NHS and published widely about its reforms. He was invited by the NHS 50th Anniversary Committee and sponsored by the NHS Confederation to provide an international perspective on the past and future of the NHS. Trained at Kings College-Sherborne, Stanford University, the University of Chicago and Brandeis University, he is professor of comparative health care systems at the University of medicine and Dentistry of New Jersey. He has won faculty fellowships at Balliol and Green College, Oxford and was a visiting professor in primary care at Manchester in 1997.

FOREWORD

The Nuffield Provincial Hospitals Trust (now the Nuffield Trust) played an important role in the establishment of the National Health Service and anticipated its organisation. Indeed, the original purpose of the Trust as defined in its Trust Deed dated 25th June 1940 was 'the co-ordination on a regional basis of hospital and ancillary medical services throughout the Provinces. . . . .'

Since its early days the Trust has had a major influence and impact on policy making and practice within the NHS. One of the Trust's current major initiatives is 'policy futures' and as part of its programme gave a grant to support the Futures Project Steering Group. Richard Smith's editorial in the *British Medical Journal* of 4th July 1998 extensively covered the initiative under the heading of *Imagining Futures for the NHS* and highlighted that familiar institutions for the NHS might be revamped and emphasised that 'the use of scenarios stretch current thinking as a wind tunnel to test current practices and plans'.

This Nuffield Trust publication provides an overview of *The NHS: All Our Tomorrows,* in particular the full text of the Donald Light report together with the Prime Minister's speech. It is a record of the Celebration Conference and a contribution to the NHS of the future.

The background technical papers* provide much useful material for developing strategic direction for health services in the UK and should be of interest to the NHS as it rediscovers the importance of strategy.

John Wyn Owen

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* The Madingley Scenarios: Two scenarios for the Future Context of Healthcare
Our Nation's Future Health Services: a report on the deliberative Citizen's Groups on the future of the NHS.
The 50th Anniversary Delphi: These background papers are available free of charge from The Nuffield Trust, *59* New Cavendish Street, London W1M 7RD.

THE 50TH ANNIVERSARY - AN OVERVIEW

Forged from diverse elements, hammered into shape by a skillful and persistent act of Labour, Britain's National Health Service converted the uncertainties and inequities of previous service into 'the first health system to offer free medical care to the entire population'.

The organisational and managerial achievements were unprecedented. Over a thousand voluntary hospitals, many in financial trouble, and 540 municipal hospitals were nationalised into one system. The very limited coverage of what was called 'national' health insurance was extended to cover everybody for all services, largely eliminating a variety of costly and uneven private insurance schemes. Extensive inequities and shortages inherited from the patchwork of charitable, private, and public provision were steadily reduced.

Today, the NHS is the world's largest health care organisation, employing about one million people and serving more than 50 million people for a mere 5.6 per cent of the nation's total income.[1] Its dedicated nurses, doctors, other clinicians, and managers work very hard. It is to honour them as well as the NHS as an enduring symbol of civilised society that the Steering Committee for the 50th Anniversary organised a three-day event at Earls Court in London during 1-3 July 1998.

The Committee decided to honour the past but also to look ahead a generation. On one hand, a poignant and extensive display of photographs at the 50th immediately took the observer back to earlier times. The 2500 delegates who attended the opening ceremonies watched a video recalling the Service's history. On the

[1]Another 1.3% of GDP is paid to private vendors for quicker or uncovered services.

other hand, the Steering Committee and the Confederation decided to launch an unprecedented look into the future. The Chairman of the Steering Committee selected John Wyn Owen, Secretary of the Nuffield Trust, assisted by Donald Light, to work with the Committee on a Future of the NHS project. Joining Professor Light were Jean Trainor from the Confederation, Philip Hadridge from the NHS Executive, Tom Ling from Anglia University, and a team of specialists on techniques for thinking about the future. Bob Sang, from the Kings Fund, used his skills as a facilitator to draw out from citizens' groups and from users their values and their concerns. Duncan Nicholson used Delphi survey methods to tap the views of managers and clinical staff about what values should guide the NHS in the future, and Tom Ling led a team on building future scenarios. To these efforts Donald Light drew on a wide literature about the UK, Europe, and health care systems to identify future challenges for the NHS. His report follows this overview.

Listening to Citizens and Users

The citizens' groups felt that in the future the NHS will need to include 'a great deal more participation' from citizens in order to produce support and consensus. Dissent is part of this process, and 'it is important that dissenting voices are heard'. This emphasis reverberated with a later speech by the international health economist, Uwe Reinhardt, when he warned that the solidarity on which taxes or premiums for European health care systems rest seems to be eroding. The citizens' groups also affirmed the core values of the NHS as a free public service, funded primarily by taxes, that largely achieves equity of access and equity of treatment. They envision by 2020 a more holistic approach to health, with NHS staff working on a 'mutually respectful basis with patients and carers'. But they are concerned about commercial interests and

priorities threatening the health service in the future. They think 'There is not much listening going on!' They want a caring, listening health service in partnership with patients and carers. And they worry that 'the NHS remains very discriminatory . . .' against minorities and the poor. Users hold similar views and worry about the fragmenting structures of service.

Surveying NHS Staff

Managers, doctors, nurses and other NHS staff who responded to the Delphi-style surveys expressed a number of values and qualities about the health service of the future. They think it should be free at the point of service and adequately funded, but are open to new ideas about how to raise the money.[2] They emphasise improving access for minorities, for people who speak other languages, and for people with disabilities. Equity received the same emphasis. NHS staff want to see more management by consent, a theme that harmonises with a central desire of users and citizens. Staff too say they want community values rather than commercial values to prevail. They also indicate that they want complaints to be taken seriously and dissenting views to be an integral part of achieving consent. They are keen on health promotion, prevention, and individual responsibility. Many of these themes are reinforced by the Prime Minister, as we may see from his speech.

Imagining the Future

Scenarios of the future were developed to provide contexts for thinking about the future of health care. Building on a wide data base about future trends in society, the scenario team identified

[2]Since the research evidence on user charges or co-payments indicates they deter both necessary and unnecessary visits and raise little money, free service is an evidence-based, sound policy.

trends shaping our future. One is new technologies and ever-larger amounts of information, with patients having ever-increasing access to them via the internet. Question: how will professionals react to empowered, informed patients? How will organisations react? These powerful changes can be taken as opportunities for more integrated, cost-effective care, or as threats to existing power structures. How can leadership ensure a positive, creative response? Shall we reconceive the NHS as a support system for self-care? It is just such a radical, yet carefully developed vision, that made Donald Berwick's speech a highlight of the 50th anniversary. Already there are more than 25,000 health and medical sites on the web, though how reliable they are for accurate health information is a worry.

From this and other trends emerged two future scenarios: Find My Way, or radically new ways of acting, and Trust Their Guidance, based on making revamped institutions work. One suggests an Age of Anxiety and Action. The other suggests an Age of Security and Being. In Find My Way, the state becomes marginal as the action bifurcates into local action and global forces. Institutions and hierarchies weaken; who is responsible for what is no longer clear. One questioner wondered if this future implied there would be no national health service as such, nor other governmental institutions. The emphasis would be on self reliance, empowered individuals and networking - all of which favour the educated and middle classes over the disadvantaged. Trust Their Guidance envisions governments and institutions taking in technological and other changes and continuing to serve as guiding anchors for citizens and patients.

The Main Event

Amidst the many interesting stands, exhibits, and break-out sessions on a wide range of topics, a parade of notable British and international speakers infused the audience with fresh and important

ideas or perspectives. David Dimbleby united all the elements and speakers with grace, pointed questions and thoughtful comments. What follows selectively features some of them.

Frank Dobson, the Secretary of State for Health, opened the conference with a powerful and substantial speech. He affirmed that a tax-based and free system saves millions by not having bills and other paperwork, while it also leaves employers with lower costs to compete in international markets. 'What some did say in 1947 and 1948, and what some still say today is that we can't afford the best for all, that the principles of the NHS aren't practicable .... Well, the last 50 years have proved them wrong.' Mr. Dobson acknowledged that staff felt 'hard pressed and strapped for cash' and promised 'the NHS will get more money - a lot more money'.

Quality was a major theme of Mr. Dobson's speech. He announced the launch of the GMC booklet, 'Maintaining Good Medical Practice' and the Government's new report, 'A First Class Service - Quality in the NHS'. He emphasised the forthcoming standards for clinical excellence and national service frameworks, as well as the Commission for Health Improvement. It will provide external checks on clinical governance arrangements, monitor clinical performance, and review information from whistleblowers. Mr. Dobson also announced several initiatives to integrate primary care with social care, link practices to the NHSNet, develop one-stop surgeries, and reduce the waiting lists, the 'number one criticism of the NHS'. He reminded listeners that the Government had put an extra £500 million into reducing them this year and promised more year on year. 'Waiting lists on their present scale are irreconcilable with a modern health service' and 'no longer acceptable.'

The Prime Minister, Tony Blair, began his speech by recalling just how heavily he, his father, his sister and his mother had depended on the good free care of the NHS. He said the NHS is 'the tangible experience of what I mean by 'community', working together - and paying taxes together - to create and sustain it in the interests of each individual in the community . . . [an] ethos at the heart of any civilised country'. The rest of his speech is appended to this report.

The Chief Executive of the NHS, Sir Alan Langlands, linked Tony Blair's vision for the future to Bevan's vision in 1948. 'The new agenda is about transforming 'bureaucratic, slow, inconvenient' into 'modern and dependable',' he said. Key strategies will 'hit the streets soon', he said, addressing information technology, human resources and funding. Services will be faster, more convenient, and designed around patients to provide uniformly high quality. 'Improving the health of the most disadvantaged must be our key priority.' Sir Alan emphasised, 'Inequality is not modern, or civilised. It is mean, punitive, and wasteful.'

Donald Light launched the session on the Future of the NHS by answering questions from David Dimbleby about how the NHS compared with other European health care systems. Professor Light said that tax-based free care is the most cost-effective way to raise money and control expenses. Primary care in the UK is amongst the best, and British specialists are superbly trained, but the NHS has fewer of them per 10,000 population than most comparable countries. The result is long and inequitable delays. In other ways as well, there is new evidence that the NHS is stressed and stretched. Professor Light said that several countries have shown a good, middle-class health service can be provided for about 8 per cent of GDP, or about £60 billion for the NHS. In other words, the NHS is underfunded by about £16 billion, which is reflected in long

waiting times, high rates of staff stress, problems recruiting clinical staff and a large backlog of capital projects. 'I see no reason why the British cannot afford 8 per cent,' Professor Light told Mr. Dimbleby. 'People in many other nations do, and if the British don't, they will pay much more for much less by paying private fees or insurance premiums.' Light's interview was followed by the main event for the Future of the NHS, an impressive video about the two future scenarios described above, Find My Way and Trust Their Guidance. Then an original playscript was engagingly acted out, portraying everyday life under the two future scenarios. The audience was highly responsive to this original contribution to the 50th Anniversary. Later, special in-depth sessions were held on the views of users and citizens, on the delphi surveys of NHS staff, and on the future scenarios.

A provocative speech was delivered by Uwe Reinhardt, a comparative health economist and professor at Princeton University. He described the ironic role that the NHS has played in the United States as 'the bogeyman of socialized medicine' that American politicians want to avoid. Unwittingly, then, it has helped to 'bestow the status of health status beggars on some 40 million American families' who lack health insurance. As for the rest, their job-based coverage should be called 'health unsurance'. How enviable a half century of universal coverage and access seems by comparison. American consultants are keen on value for money, and the NHS provides amongst the best in the world.

But can the social solidarity underpinning the NHS continue? Globalisation is creating an affluent international class and local families of modest means. International health care companies are creating upper-tier carve outs, like surgicentres, for the upper tier who can afford private fees. If this is resisted and taxes are raised

to have a good service for all, 'the elite will preach the virtue of tiering by income class, for the sake of 'personal empowerment', of 'individual responsibility' and, most important of all, for the sake of 'efficiency', a technical world so often used as a camouflage of mere ideology.' They will protest the increased tax burden. But if the British keep taxes low, the private entrepreneurs will hollow out an increasingly antiquated and shoddy NHS. Professor Reinhardt closed by parsing the difficulties of finding good measures of accountability and making clear who is accountable to whom for what.

Stephen Thornton, the Chief Executive of the NHS Confederation, emphasised that the Green Paper on public health and purchasing for health gain represent a radically new agenda: from thinking about health services to focusing on health, and from a short term to a long term perspective. 'It will require performance management that is as tough on reducing teenage smoking and pregnancy rates as on reducing waiting times for non-urgent hospital treatment.' Public health is the foundation on which the health service rests, and Thornton reminded us that the NHS 50th takes place in the context of the 150th anniversary of the first Public Health Act in 1848. Under it were hired officers of health. Opposition was stiff, and even when faced with an outbreak of cholera, The Times thundered, 'we prefer to take our chances of cholera and the rest than be bullied into health'. As for inequality, Thornton said, 'To improve the health of our poorest communities will require disproportionate effort - what one health visitor in Maidenhead can achieve might take five in Toxteth' .

Mr. Thornton turned to the pressures of budgetary limits on services - waiting lists that resist downward pressures, expensive drugs selectively denied, and rationing by dilution of quality. He urged

that widespread public debate take place about fair limits to care rather than having de facto 'service inequities without any clear rationale'. Thornton also argued that the relentless rise in demand for acute care be shaped and managed in equitable ways. Patients and their GPs need to know and discuss the downside risks of various interventions. Drugs need to demonstrate that they are cost-effective, a 'fourth hurdle' that 'could have a dramatic effect'.

To meet these challenges will take political courage and board members 'with a talent for networking and alliance building', not those 'whose track record is the business world, the cut and thrust of contract negotiation, of beating the competition, of winning at all costs'. Managers will need to acquire skills for community development and for managing health.

Thornton's challenging and wide perspective received strong support from Donald Berwick's transformative model of health care for the 21st century. Set in 2023 at the 75th anniversary of the NHS, Berwick looked back to the revolution in health gain and cost savings that occurred after the NHS implemented eight principles after 1998. They culminate in health care being organised as support services to enable patients and their families to care for themselves. 'Service is not an amennity; it lies at the core of our purpose.' Berwick's evidence-based model rests on studies showing that patients who learn to measure their conditions and treat them achieve superior results and high satisfaction (at lower cost) than patients who are 'treated'. In this model, waiting costs more than it saves, as evidenced by the 25 million person-days of suffering by the 50,000 patients who wait an average of 500 days for a hip operation as their joints deteriorate. As Berwick put it, evidence shows that 'Waste costs more than it saves'. Reducing waiting times and other forms of waste, however, requires developing a positive

culture of teamwork dedicated to improvements and spreading best practices, to replace a more fragmented culture focused on identifying and disciplining worst practices. 'Measuring for improvement is not measuring for judgement.' In conclusion, the NHS in 2023 will be 'full of knowledge, continually improving, taking the best as its norm, a fully integrated system of shared and cooperative effort. . . offering the people it helps the fullest possible control over their own lives and experiences'. The complete speech and its evidence base are published in the 4 July issue of the BMJ.

Many other distinguished speakers contributed to the plenary programme and several of the break-out sessions. Thousands of NHS staff, patients, and friends visited the many stands assembled by scientific, commercial, and public bodies and delegates judged the event a resounding success.

We should like to record our appreciation to all involved.

Karen Caines
Per-Gunnar Svensson
Stephen Thornton
John Wyn Owen (Chairman of the Futures Project)

FUTURE CHALLENGES FOR THE NHS ON ITS 50TH ANNIVERSARY: AN INTERNATIONAL PERSPECTIVE

The Golden Anniversary of any institution, especially a world-class one, is a fit occasion to celebrate what has been accomplished, but also to think about the challenges that lie ahead. One could write a book about both, but this report aims to address several themes briefly and to pose a number of major challenges. The Steering Committee for the 50th anniversary decided to choose a knowledgeable off-shore observer to define those challenges from an international perspective. This report thus reflects my views and not necessarily those of the sponsoring institutions. I think it will get you thinking about a number of important issues.

An International Perspective

Two comparative strengths of the NHS strike one right away. It raises funds through income taxes and it has what an authoritative study concluded is the best primary care system in the world. Let us look at each in turn. Compared to forms of health insurance, income taxes are the cheapest and most fair way to collect funds. They also help to hold the health care budget in check, because health care has to compete against other major programmes (like education and economic development) every year to get its share. As a result, the costs of the NHS (but not of all health care, including private care and the 'independent sector') are well below the average costs for a country of its income class. The UK is one of seven countries in Europe with well-established tax-based systems, the other six being Norway, Sweden, Denmark, Finland, Iceland, and Ireland. They all have good records of cost constraint.

Competition and Costs

NHS costs jumped between 1990 and 1992 from a full per cent of GDP (gross domestic product) and has levelled out since then. That jump coincided with converting the entire system from one of public administration to managed competition, though how much of it

was due to higher transaction costs is a matter of debate. Some believe that managed competition was alien to the ethics of the NHS. Others believe it was the right idea but inadequately supported or pursued. The Swedish view is that the British transformed their entire system but then did not give it bite. For example, the Swedes really did have money follow patients; if patients chose one obstetrical service over another, that service received more funds, and other services received less. The Swedes also declared that if patients waiting for certain elective operations did not get them within three months, then the patients could make their own arrangements to get the surgery, and the county council [the health authority] would have to pay. As a result, waiting times plummeted. Sweden actually succeeded in getting its health care costs to drop, from 8.6 per cent in 1990 to 7.6 per cent in 1992, where it has stayed ever since.

Primary Care

The other great strength of the NHS is primary care, and British patients use their GPs much more than in other countries. Recent changes will put an even more comprehensive array of services into the hands of local GP practices. Prevention and public health will be helped by this broad organisational base, and comprehensive primary care should be an effective vehicle for handling the widening gap between demand and need. But more on that later.

The recent analysis of European systems by WHO points out that capitation payment systems hold utilisation down better than fees, another plus for the British approach. The new White Papers are a model of what the WHO analysts say needs to be done: give primary health care providers incentives to substitute for secondary care and have performance measured in terms of evidence-based outcomes. A key question is how much risk providers should bear and over

what base? So far GPs have not borne much, if any, downside risk of losing money. With the formation of primary care groups, that may change.

Dissatisfaction

British surveys consistently show a high level of satisfaction and support for the NHS, but a comparative survey done at Harvard University that asked samples in five countries how much change was needed in their health care system found that more British people said that fundamental change was needed than people in any other country except the United States. Both views might be true - a strong appreciation for the NHS but also a feeling that fundamental changes are needed.

The NHS provides fewer nurses and specialists per thousand population than any other country in Northern Europe. It also provides amongst the fewest beds and bed days per thousand, the longest waiting times for elective surgery, and the most run-down buildings. Is it worth an extra one per cent of GDP to solve these problems? Or would it be better to spend it on education, employment or housing?

CHALLENGES FOR THE FUTURE FROM THE PAST

While one can learn from the experiences and ideas of other nations, in the end most countries have their own history, their own politics, and their own institutional past. That history gets built into current budgets, regulations, and organisational structures. It also shapes debate and proposals for change, as they have since 1974 and before. Let us look at some key challenges from past decisions now embodied in present arrangements for the future.

Besides creating a single, national basis for collecting funds, the NHS created a single, national system for providing services. It filled gaps and reduced inequalities. As Charles Webster's new history of the NHS shows, it was quite a struggle. The NHS almost didn't make it. One could almost say, if Hitler had not threatened the nation's existence, factions would not have come together to form the NHS fifty years ago. 'The polarization of attitudes experienced at [the] time was deeply damaging and it cast a long shadow over the future of the NHS.' For within the national service were divisions and fiefdoms:

- GPs under a separate contract outside the rest;

- specialists on salary inside the NHS but with extensive powers to do as they wished;

- community care floating in a no-man's-land between hospital and primary care;

- teaching hospitals pursuing their own agenda under separate governance.

In previous years, leaders of the medical profession had put forward a number of proposals for integrated care but had great worries

about Bevan's initial design. The compromises have had their price. As Tom Ling has recently put it in his work "The British State since 1945", 'The medical profession's stubborn resistance was rewarded by an administrative system which left them . . . broadly beyond the control of NHS management'. The reforms since 1974, even up to this day, are various attempts to unify these fiefdoms.

Challenges to Primary Care

Based on experiences with capitated contracts in HMOs, American observers would immediately be concerned about GPs dropping sicker patients from their lists and referring on too many problems in order to reduce those costs. Yet these seem to be secondary concerns in the UK, and not much attention is given to either. Is this because British GPs are more altruistic and dedicated than their American counterparts? Or are British policy makers uninformed as to whether risk de-selection and cost shifting are taking place in some primary care practices? If primary care groups bear more risk, will bias selection get worse in the future?

Another difference is that American HMOs think that primary care itself needs to be commissioned and monitored. They worry not only about de-selection and patient shifting, but quality. One suspects there is a lower third to general practice that needs to be addressed, especially since it is the clinical foundation on which the entire health care system rests. Does primary care in the NHS need to be commissioned, and if so, by whom?

The Future of General Practice

Since the founding of the NHS, GPs have been protected by an independent contract. Yet functionally, U.S. and British experiences indicate that two-thirds of primary care work can be done by less expensive nurse-practitioners (NPs). Even a less-trained American

physician's assistant (PA) was reported to handle three-quarters of GP work in a Reading practice as early as 1980. Isn't it odd that a cash-starved NHS didn't run with these cost-saving innovations? If it did, what would GPs do besides supervise? They could take up minor problems they now refer to specialists, although GPs have been slow to gain the requisite specialty skills and practice equipment to do so. On the other hand, if specialists wanted to, they could easily move down into the primary care domain, as they have done for decades in the United States.

Question: If primary care is moving towards team practice within one budget, what will be the functions of the general practitioner that make economic sense? As the historian, Frank Honigsbaum warned in 1985, 'General practice is in danger of being caught in a pincer movement with inroad on care being made both from the hospital and from members of the primary care team'. Future funding arrangements will make this danger a reality, unless protectionism wins out over cost-effectiveness.

One obvious answer is for GPs to become semi-specialists who spend their time (when they are not supervising NPs and PAs) with sicker, more complicated cases and with minor specialty problems they now refer. But this will require an array of brief training courses, an interprofessional level of interaction, and a system of quality assurance and accountability that do not exist now. Telemedicine hook-ups to specialists could play an important role here. Without proper training and support, GPs could end up doing more specialty tests and operations incompetently, as some think has been the case in recent years. Are the Royal College and the government preparing general practitioners for the future with a well thought-out programme, as their historic protections fall away?

Challenges to Hospital Care

Modern technology profoundly threatens the concept and costs of district general hospitals, because so much of specialty medicine no longer requires large buildings and overheads to diagnose and treat. Most of the inefficiencies and waste are in hospitals. The big savings lie in reconfiguring specialty services to minimise hospital admissions and length of stay; but that implies reconfiguring budgets and stepping on some big toes. Are ministers and managers ready to do that? By 2020, how should NHS contracts be configured to minimise entrenched waste and maximise efficiency and accountability?

Challenges to Community Care

How should community health care be integrated to primary and hospital care by 2020? It needs to be combined with hospital care in order to enable prompt, coordinated discharge; but then it runs the danger of being crushed by a 400-pound, cash-starved gorilla. It could (and is being) combined with primary care, but then one runs up against budget barriers. Does integrated community care imply team contracts and team training?

Rivett's Challenge

At the conclusion of his important new history, Geoffrey Rivett worries about the continuous string of organisational upheavals and concludes, '. . . I would not claim that there has been a major improvement in the value added by management over the 50 years of the service'. I take him to mean not that good managers don't add value, only that reorganising services has not improved the value of management. Is he right? Would managers manage better if they could concentrate on their jobs, rather than having to spend half their time addressing the latest reorganisation? Or are the reorganisations moving the NHS towards better management structures? A useful exercise would be for groups of managers to

review the major reforms since 1974 and draw up a balance sheet. It would give them a useful historical perspective with which to face the future.

Rivett identifies a number of other challenges for the coming generation as well. One concerns the need for something to replace the defunct firm system, in which each patient was the responsibility of a single consultant. Rivett sees consultants, nurses, junior doctors and other staff rushing around these days in a harried service. 'The result may be inefficiency, and sometimes inhumanity,' he writes. A number of models exist, like disease management teams using clinical pathways. Which model should the NHS aim to develop in the next generation?

Klein's Challenge

In his authoritative history of the NHS, Rudolf Klein identifies several dilemmas that almost any national system faces. One of them is how to get the balance right between centralisation and decentralisation. For many years, the prevailing policy has advocated making decisions as close to the patient as possible. But are the devolved decision-makers (whoever they are) capable and ready to take on greater responsibilities?

Local control is likely to mean greater variations in quality and greater inequality. How shall those problems be addressed? Devolved decisions can also fragment planning and the coordination needed for area and regional services, unless we are talking about delegation rather than devolution. On the other hand, central control minimises local participation and tends to be insensitive to differences in local circumstances and needs. It also tends to get administratively fossilised, as one can see in the East German health care system, which went from being a model of health-oriented,

coordinated care to being silted up by bureaucratic rules. What kind of balance between centralisation, delegation, and devolution do we want to see develop?

Current British policies reflect European efforts by many European states to renegotiate themselves through the 'new public management', an attempt to combine central standards of performance with hands-on local management. Does that solve the problem? Has Klein's challenge at last been met? To what extent is there, in Ling's paradoxical phrase, 'the tendency for states to fragment over the countervailing tendency for states to cohere . . .'?

The Challenge of Unco-ordinated Information

In order to reduce inefficiencies, the bottom third of quality, unnecessary services, ineffective treatments, and service fragmentation, one needs good clinical and financial information. Yet for the most part it is lacking. This core problem has remained unsolved for years. Most purchase-oriented systems think that such information is vital; otherwise purchasers can neither know what they are getting for their money, nor estimate how they could get better value.

The NHS reforms have allowed multiple data systems to develop and left trusts to gather what data they like. Although all patients have a unique identifier, no system has evolved that allows one to track and assess the range of services throughout a patient's course of illness. On the other hand, systematic reviews have found limited evidence of benefits and savings. Across the GP - hospital divide, it is unclear who is to pay for what and who owns which data. The co-ordination and regulation of effective data systems takes us back to Klein's challenge of getting the central - local balance right. What steps can be taken to move the information agenda forward?

FUTURE CHALLENGES OF NEED AND DEMAND

There is widespread fear that over the next generation health and welfare costs will inexorably rise, driven by an ageing population, and therefore the NHS is not sustainable in the future. I have reviewed the data, and this conclusion seems largely unwarranted. Since these data are the foundation for thinking clearly about future challenges, they seem worth reviewing quickly.

Trends in Health Care and Welfare

An authoritative 1997 report by John Hills for the Rowntree Foundation provides a reassuring picture. It shows that health, education and welfare costs for the UK have fluctuated around 25 per cent of GDP (gross domestic product) since 1973. They are not spiraling up. From an international perspective, British costs for these basic services of a civilised society are the lowest in Northern Europe. In fact, only Portugal and Greece are lower. I think the British can easily afford the current levels of comprehensive health services in the years to come. They can even afford to pay for better, quicker services in nicer buildings. Europeans in many other countries do.

As for ageing, the UK trends are as reassuring as the trends on health, education and welfare. The UK has already experienced a substantial portion of its ageing burden. By 1991, 16 per cent were over age 64, and ageing pressures are likely to ease up in the coming years. The proportion of people over 64 will slowly rise, but even when multiplied by the higher levels of health care and social supports needed by those over 65, 75, and 85, the increase in spending will average a mere one-third of one per cent a year over the next 50 years. For similar reasons, the 'support ratio' of working age people to elderly people will decline less than in any other country except Norway.

The structure of British national health care also gets good marks for accomplishing its larger social functions:

- It cushions people from high bills when they get sick.

- It redistributes resources towards the neediest people with chronic or serious health problems.

- It smoothes out income over the life cycle by taking in proportionately more money during productive years and paying out more after retirement.

Older Americans on Medicare sure wish they had that. They pay out 25 per cent of their retirement income for health care expenses, because coverage is so incomplete.

The Challenge of Rising Demand

Despite these reassuring basic trends, short-term demand seems up everywhere. Hospitals are inundated with emergency admissions and visits to A&E departments. GPs feel swamped by demand, and there is talk of a new waiting list - to see your own GP! Yet there is no evidence that people are actually sicker.

Beyond these recent pressures, few people doubt that demand is and will be rising steadily. People expect more and better service. The post-War ethos of forbearance is gone. People expect to look good and feel good. An American doctor recently quipped about a new syndrome: the Prozac-deprivation disorder!

What can be done to keep rising demand from allowing the NHS to meet real need? Some American HMOs are at the forefront of what they call 'demand management', an array of techniques using patient education, advice lines, telephone screening and protocols to reorient demanding patients. Is that what NHS clinicians and managers need to develop as the 21st century unfolds?

Integral to the challenge of rising demand is the information revolution and the internet. They cut both ways. On one hand, patients are already arriving at their GP with printouts about their symptoms and treatment alternatives. They can easily obtain sophisticated - or erroneous - medical information and medicines off the internet. Pressures and patient demands could skyrocket. On the other hand, people can do a lot more self-diagnosis and self-care. The internet and other sources of information or help could get people much more involved in their own care and take pressure off the NHS. How do you think this scenario will play out? What should be done to develop and steer it?

One way to empower patients and enable them to manage more of their health problems is to encourage self-help (actually, mutual help) groups. In New Jersey alone, we have a directory of them that fills more than 200 pages, double-column, in 6-point type. Moreover, a toll-free number takes the caller (a patient, a friend, a clinician) to a helper with an on-line list that is updated weekly and indexed by area and disorder.

> *I'm calling from Cheadle and looking for a mastectomy group.*
> *Let's see, there's no group in Cheadle on my screen, but there is one in Gatley that meets Tuesdays at 7:30 and here is the number.*

Hospitals, doctors' practices, and other organisations offer the use of rooms and office facilities. A low-budget state program sponsors leadership training, advisory services, and networking conferences.

Mutual-help groups have an extraordinary range. They enable people to help each other and cope with addictions, circumstances

(being unemployed), physical losses (amputees), deadly diseases (cancers), life's losses (bereavement), and a very wide range of mental health problems. Mutual help groups have their problems as well, but on balance they would seem to benefit the NHS in several ways. How extensive do you think the role of mutual-help groups should be by the year 2020? What steps should be taken to achieve your vision?

Rising expectations and demand suggest to me that the NHS needs a new social contract with the people who pay for it and use it. The 50th anniversary is an ideal occasion for drawing up that contract and discussing its terms.

The Challenge of Future Pandemics?

Generally good health, alongside long-term disabilities and diseases, may characterise modern societies, but epidemics or pandemics could catch us all by surprise. Take, for example, the effects of antibiotics used in chickens and other animals. They have a dual effect. On one hand, virulent mutations could develop rapidly throughout large populations of chickens and be consumed by humans. At the same time, our immunisation systems are weakened by the antibiotics we ingest. The overuse of antibiotics in medicine for minor and self-limiting disorders is also threatening our ability to resist a wide range of infectious diseases such as pneumonia, meningitis, and tuberculosis. We face, according to a recent report from the House of Lords, 'the dire prospect of revisiting the pre-antibiotic era'. The problem has the WHO worried on an international scale. This danger looks very serious. Are we doing enough in terms of infection control standards and protocols to address it? Is enough being done in public education and in the food industry to reduce risk to the entire population?

MAKING THE NHS INTO A REAL HEALTH SERVICE

Let's face it. Aside from some screening, immunisations and patient counselling, the NHS is largely a *medical* service, an NMS. Or is that unfair? It was Beveridge who saw more than 50 years ago that Britain should have a health service that fully integrates prevention and public health. How might that mandate or vision be best realised? What financial or organisational changes would it take to happen in the next 10 to 20 years?

The payoff could be large. A prominent American group of research and policy leaders has concluded that 70 per cent of diseases and disorders can be prevented or postponed, saving billions in acute services. As Morton Warner has shown, a true health care service could greatly reduce the number of services needed. But the NHS does not measure or reward wellness or health gain. If a primary care team prevents hospital admissions by managing asthmatics well, ('secondary prevention'), the segmented budgets mean that they increase their own costs without any of the savings coming back to them. Successful prevention is just an added cost. Within a few years the team will typically run out of money, abandon the programme, and acute costs will go up on somebody else's budget. There are important efforts to integrate public health into the NHS, but what is needed is much more - a new form of accounting and a reformation.

The Reformation had revolutionary effects because translating the Bible into the vernacular rather than into Latin enabled parishioners to replace their passive, dependent relationship to the clergy with an active and interactive relationship. That is what a health service implies. That is what the internet and the information revolution will produce, whether the medical priests are ready or not. Managers can make a big difference in the speed and direction of this revolution.

THE FUTURE OF GOVERNANCE

User Involvement, User Vote?

User involvement is an effective way to

- get patients to manage more of their health problems,
- move the NHS towards being a health service, and
- save money.

In 1979, the Royal Commission on the NHS said it 'is a service for consumers and any discussion of performance must start with the views of the patients it is intended to serve'. The term 'consumers' was a notable choice in 1979; yet today the NHS does not begin to consult or listen to its consumers.

In 1988, a commission on the NHS chaired by Julia Neuberger stated, 'One of the best features of the National Health Service is its commitment to provide care and treatment for all on the basis of need, rather than ability to pay. One of its worst features is the extent to which it fails to take into account the views and wishes of those who receive this care and treatment.' The report continued, 'The concept of 'self-empowerment', implying a radical change in approach to health and sickness by both patients and professions, acknowledging the individual's right to control his or her own life, must be encouraged at all levels'. Not informing and empowering patients, especially those with long-term conditions, creates disjunctures in care that are wasteful. When patients do not understand their diagnosis or treatment plans, and the implications for their lives, they are less likely to comply or know how to manage their problems.

A recent report for the Long-term Medical Conditions Alliance, the King's Fund and the NHS Confederation notes that national policy

requires users to be involved in setting standards and in developing policies. This is a far cry from practices today. It seems to me that for a 'national health service' in a democratic country, the NHS is surprisingly hierarchical and autocratic. This has two future dangers:

- Patients and taxpayers will increasingly feel disenfranchised so that an NHS run by remote boards is likely to lose legitimacy.

- And organising services into managed care groups run by executives sets them up to be run by corporations under outsourced contracts ten years from now.

It seems to me that either the NHS must become more democratic, or it will become more corporate. Do you agree? If so, what would you like to do about it?

Setting Policies, Priorities

At the level of setting standards and policies, the *New Agenda for Health* states, '. . . the NHS is a public service, paid for by the people, belonging to them and intended for their benefit. Citizens therefore must have a voice in how the NHS is run.' The authors describe how the conservative government reduced local accountability, centralised accountability in the name of decentralisation, and carried out rituals of listening to local voices. But now there is a new commitment to patient involvement and openness. Given this commitment, we can think about changes for the next generation?

- How should the public be involved in setting standards and making policies?

- What procedural rights should be established to frame and protect that involvement?

How should basic principles and priorities be set?

What substantive rights should patients have to health care?

A Federated Service?

The White Paper may talk about a 'one-nation NHS' but it looks to me as if the UK is heading towards being a federation of states: Scotland, Wales, Northern Ireland, and England. I cannot get too worried about this prospect, but it does create complexities. If health services federate, of what powers and functions would the 'National Health Service' consist? Or would there be four?

CHALLENGES OF RECRUITMENT, TRAINING AND RETENTION

Between now and 2020, the NHS will have to recruit and train a large and steadily growing number of nurses, doctors, clinical specialists, and managers. Once trained, one wants them to have full and productive careers, not only as a return on investment but also for the sake of NHS patients. I am no expert, but it seems to me that the conditions of work, the level of pay, and the chances for promotion are becoming less and less attractive for the young men and women one wants to recruit compared to other lines of work. John Chisholm at the BMA states, 'We are facing a crisis of recruitment and retention'. Compared to 20 years ago, young adults face a growing range of attractive career opportunities. What do you think? When you talk to younger friends or older children, how does a career as a nurse, or physiotherapist, or midwife, or GP stack up against the alternatives?

- How much of the problem is level of pay?
- How much of it has to do with career ladders with only two or three rungs?
- What role do you think working conditions play?
  - Physical conditions?
  - Appreciation and respect?
  - Communication and teamwork?
  - Sense of accomplishment?
  - Workload and stress?

A new report from the Nuffield Trust on the health of the NHS workforce sheds light on some of these dimensions. The work, as we

all know, is inherently stressful: staff must deal with patients' physical and psychological problems, with dying and death, and with heavy clinical responsibilities. Therefore, good communications, teamwork, a sense of accomplishment, a sense of learning, and advancement are especially important. Apparently, many staff find them missing.

- NHS staff quit at high rates, creating a high level of wastage for the Service and high replacement costs.
- Doctors 'are increasingly seeking early retirement'.
- Work is getting more intense, and hours are getting longer.
- In hospitals, patients come in sicker, and there is less time to treat them before they are hastily discharged.

At the same time, the Nuffield report continues, patients have higher expectations and complain more - or sue. Fear of litigation adds further anxiety to an already stressed-out staff.

Overall, levels of psychological disturbance are fifty per cent higher than in the general workforce. Depending on the study, up to half the hospital doctors, GPs, nurses and managers report 'psychological disturbance, ranging from emotional exhaustion to suicide . . .'. Clinical staff in the lower ranks report:

- lack of adequate resources,
- lack of role clarity,
- high workloads,
- insufficient training for the work they are expected to do,

- lack of control or say over their work,

- discrimination, and harassment.

The Nuffield report reviews and recommends a number of positive interventions that can improve communication, support, interpersonal skills, and work environment. But will they be enough to recruit and retain good clinical staff of all kinds and grades over the next decade or two? As you can see, they do not address pay levels, career ladders, or the more costly structural problems of work conditions.

FUTURE FUNDING FOR RISING DEMAND

Basically, the NHS keeps getting more productive and provides a remarkably comprehensive service on an internationally low level of funding. Further, as indicated above, recent rises in demand do not reflect greater need and could be addressed by developing a new social contract with patients that mobilises as active partners in managing many symptoms and problems. In addition, there is room for even greater productivity by reducing inefficiencies within current services, though tackling them would require taking on powerful entrenched interests. (This is another reason for involving the public more, to gain their support for what is entailed in reducing waste and increasing productivity.) Nevertheless, at the end of the day, an optimistic realist is still left with good reasons for believing that the gap between services and funding will widen.

- The increased workload from ageing, though less than in most countries, will occur. People will also live about 4 years longer in 2020 than now. The number with long-standing illnesses and disabilities is slowly rising.

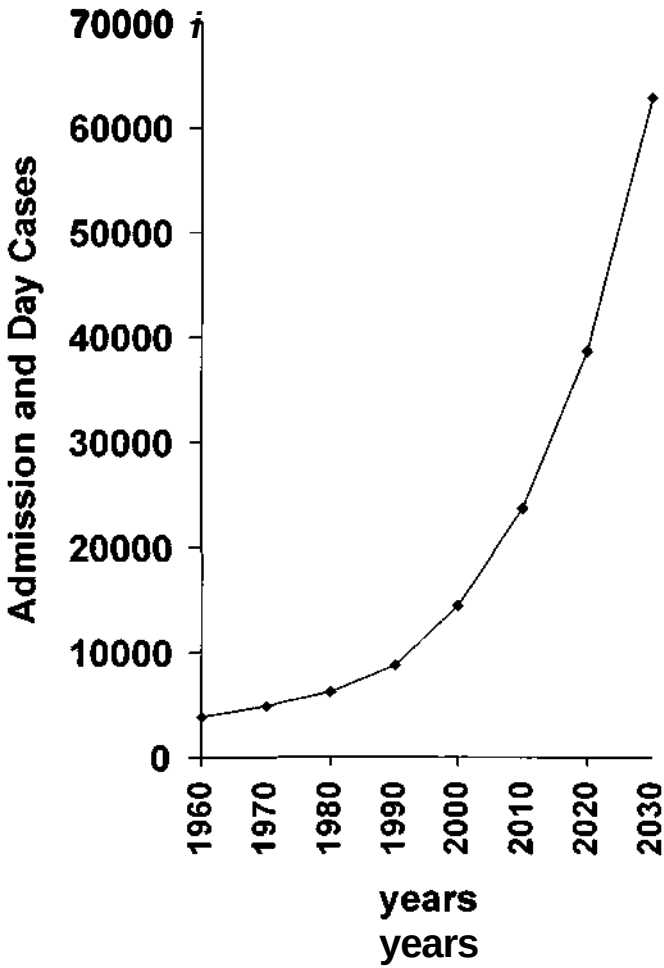
- 'Need' will grow steadily as medical advances enable doctors to diagnose more and treat more.

- The number of specialty episodes has been growing steadily at 5 per cent a year. If that increase continues (and it could easily rise), it would mean that while the NHS did *6.3* million in 1980 and 8.8 million in 1990, it would have to do 14.5 million episodes in 2000, 38.6 million in 2020 and 64 million by 2030. Figure 1 makes you rethink future funding.

The NHS is widely perceived as rundown, with a backlog of about £3 billion of capital improvements needed.

The high levels of stress, sickness, and turnover in NHS staff indicate that major investment will soon be needed.

Admission and Day Cases- England 1960-2010



source: 1960-1990 Geoffrey Rivett; "From Cradle to Grave", 199
2000-2030 continue series at past rate of 5% increase per annum.

While only 9 per cent of the population is covered by private medical insurance, about 22 per cent of the professional and managerial classes have coverage, and amongst them the quality of NHS services is widely perceived to be unacceptably uneven and slow. Still more people simply pay for private treatment out of savings. Yet this is the key group for legitimation and support of any institution.

In international surveys, more British said that health services needed fundamental improvement than people in any other country except the United States.

Limit the NHS to just Emergency and Acute Services?

Does this evidence of a widening gap between funding and a good comprehensive service mean that the NHS should - or will have to - narrow its services to emergency and acute interventions? Some people think so, but then they conclude up front that the British cannot afford any more than their very low level of funding, while comparable countries contribute enough to pay for good comprehensive services. This question really comes down to values and priorities. The focus groups and the professionals we surveyed for the 50th anniversary certainly did not express these sentiments.

What do other countries think? The Swedish set up a Priorities Commission, and they concluded the opposite: highest priority should go to treating patients with life-threatening diseases and those with severe chronic disorders and terminal diseases. That is, they put unadulterated caring of the most seriously ill and disabled ahead of many treatments that might be called 'evidence-based' or that might produce more quality of life years. In the US, outcomes research has defined 'outcomes' broadly to include the quality of a patient's social and intimate life.

When in 2010 or 2020 you are laid low, or in pain, or about to exit this world, do you want compassionate care from nurses and staff in the NHS? Is that a priority or more of a luxury you think is not worth the extra cost? In our focus groups, citizens and patients sounded positively Swedish. On their own they said caring was a core value, a high priority. In making our own decision about this question, it is worth remembering that the more narrowly health care services focus on acute intervention, the more they exploit the unpaid labour of women and discriminate against the working classes. Think about it.

'Rationing' as a Misleading Option

Another way to bridge the widening gap is to ration, and indeed it is as fashionable to talk about its inevitability as it is politic to pretend the word does not exist. But I want to make a different point, that policy leaders who talk about rationing presume no more funds can be raised, rather than asking the people whose bodies and money are at stake whether they are willing to pay more. Rationing arguments presume the answer is 'No' without asking. They are paternalistic, especially in a country that can so obviously afford to pay more if people want to. All moral philosophers agree that such choices and alternatives must be discussed fully with the people affected.

Go Private?

Internationally, affluent people pay privately for medical services everywhere. Private care is an easy way for politicians to provide an outlet for discontented managers and professionals. The danger is that if it becomes too extensive, it threatens the legitimacy and solidarity on which the main service depends. For example, the extent of private practice by GPs and consultants in London makes some European observers wonder whether these doctors see

themselves primarily as part of the NHS, with some extra patients on the side, or as private practitioners who get paid by the NHS for some of their patients?

Private consultant practices, by the way, seem to me to give poor value because patients cannot compare charges. As a result, consultants charge exorbitant rates, higher than on Fifth Avenue in New York, and even clever patients cannot compare price and quality. Private insurance provides poor value as well. Insurers operate under rules that allow them to select what procedures they want to cover and leave all the rest with the NHS, like a parasite feeding on and slowly destroying its host. Other countries lay down fair rules for private markets. If you are going to have private markets, at least make them fair - to the NHS and to the patients going private. End of sermon.

Allowing private services to grow is a limited strategy for closing the gap between funding and future demand that can actually make the gap grow larger if it undermines the legitimacy of the NHS. Any other ideas?

A Supplementary Health Care Contribution

Such a tax would address a major concern for the 60-70 per cent of the population who say they think more money should be raised for health care, but they are afraid that their money will be used for other things but health care. It should be called a contribution, and it would go exclusively for health care.

The health care contribution would have to be supplementary, or the Treasury will stop allocating 14 per cent of the government budget to health care. Even better, it could be ear-marked for services people really want, like elective surgery, or upgraded facilities, or good care for old age. It could start out small - 1 per cent -

and then grow as people chose. This is another advantage to a mandatory health care contribution: it helps a democracy focus debate on a single figure and what it will buy. As the 21st century unfolds, a supplementary contribution will probably become a valuable source of additional revenue.

This same idea could be done as a supplementary health insurance plan. Then the premiums would not count as part taxes.

A Voluntary Contributory Scheme

Another way to providing funding for rising demand over the next 20 years is to establish ground rules for voluntary contributory schemes. Functionally, these are like private health insurance in that they are a voluntary upgrade for quicker or better service. But they can cost less than half the price and be community-rated so they do not discriminate by age or health risk. They can also be structured so they support the NHS rather than exploit it. They can be so cheap that anyone from working class or higher can participate. The right kind of scheme would be a private/public partnership between employers, workers, and the government.

What do I recommend? I think there is a clear challenge to fund rising demand, and I think you should do everything. Establish fair rules for private insurance and care AND set up a supplementary health tax AND establish ground rules for contributory schemes that support the NHS. Get every new source of funding started and see how each unfolds.

SUMMING UP - THE CALIFORNIA CHALLENGE

The California challenge for the NHS by 2020 is to become a real health service, to get serious about integrated care, and to stop being hobbled by its segmented and protectionist contracts. Then it might look like this:

- long-term, risk-adjusted contracts to provider consortia to minimise illness and maximise health gain.
- Patient-based measures of quality.
- Integrated data systems that track quality, cost and effectiveness.
- No distinct contracts for hospitals; consortia would buy what they need.
- Clinical services by certified performance, not by historical licenses.
- Clinical services by health care teams that are trained as teams and receive team-based compensation by performance.
- Community-based public health programmes.

Of course, even the best California health care systems are limited by not having what the UK has already - universal access, stable population bases, health authorities (which American employers are trying to create), and a service ethos rather than a profit ethos. In other words, the UK is better positioned to achieve an integrated health care system for everyone than the US. Think of it: Leeds could leapfrog L.A.!

The Prime Minister,
The Rt Hon Tony Blair's
Speech at the 'All Our
Tomorrows' Conference

On the Occasion of the 50th Anniversary of the National Health Service

Earls Court

2 July 1998

For my generation the NHS has been a fact all our lives. We were born into it, we grew up in the knowledge of its existence. My family childhood was, looking back, dogged by illness. I knew Dryburn hospital in Durham better than any other institution than school. My father having a stroke that left him learning to speak again. My sister, best of the part of two years living in the hospital with rheumatoid arthritis, my mother eventually dying of cancer in its care.

All terrible events. Yet whatever grief and worry and anxiety we had, we never once doubted that the care and quality that the NHS guaranteed would be there for us. Merely to pay for care was never one of our hurdles. At least we were free. Thanks to the NHS.

It is the embodiment of the values I believe in. It symbolises the right of every human being to the dignity of healthcare based on need not wealth. It is the tangible experience of what I mean by 'community', working together - and paying taxes together - to create and sustain it in the interests of each individual in the community. It is driven and maintained by public service, by people dedicating themselves to the service of others. That ethos is at the heart of any civilised country.

Learning from the history of the NHS

As we celebrate the 50th anniversary of the health service it is an ideal time to learn from its history. It came about because people feared becoming ill, not just fear of diseases like diphtheria, tuberculosis, pneumonia and scarlet fever - but fear of not being able to pay the doctor's bill and the medicines that were prescribed. There was no uniform service. Responsibilities were split between health committees, rival hospitals and charities. Hospital buildings were in an appalling state. The quality of service was very variable

and there had been a refusal to modernise, to confront the problems everybody knew existed.

It took the vision of Beveridge, the dynamism of Bevan and the commitment of the then Labour government to make order out of chaos.

As the first NHS patient, Sylvia Diggory, put it as she looked back on meeting Aneurin Bevan as a 13-year-old girl in hospital on 5 July 1948:

> *Britain is one of the few countries where they feel your pulse before they feel your wallet if you collapse in the street.*

Since then the NHS has provided better and better care: the national immunization programme ensured that killer diseases like polio, smallpox, TB and diphtheria were conquered. Universal access to primary care for all citizens. An 80 per cent reduction in the number of children dying before their fourteenth birthday.

Life expectancy for men up from *66* to 75 years, and for women up from 71 to 80 years. A proper system, following the experience of thalidomide, for making sure that new drugs are safe to use.

People are sentimental about the NHS and rightly. But most of all they believe it works. It is the best way to provide healthcare.

Yet today they are worried about its future. We want the confidence back that the NHS will be there for our children and grandchildren in the same way it was there for us.

Fifty years ago that Labour government had the courage to create the NHS. Now it is the New Labour Government that must give the country back the confidence in its future.

And I don't mean we must simply 'save the NHS'. We must do better than that. This week should not only be the celebration of the past. It should set out a vision of the future of an NHS fit and able to succeed in the 21st century.

That is a huge responsibility for the new government. It has been made harder by an insistence that we had to apply very tough financial limits for our first two years of government. We did that because we had to cut the very large debt of the government - doubled in the six years to 1997 - and to put the economy and public finances on a sustainable footing.

That is not to say no new money has come through. We increased the spending plan we inherited by £300m the first year and 1.7bn for this year.

The new hospital building programme - the largest ever for the NHS - is now under way after years of delay.

But I know it is not enough.

However, subject to these constraints, we have tried to do three things. We have tried to restore the values of the NHS - co-operation and partnership - to their rightful position at the core values of the service. Not all the Conservative policies were wrong. But having a crude market system where hospitals compete against hospitals and doctors against doctors was never a sensible way to reform the NHS.

Secondly, we have put forward a programme of change and modernisation, which if radical, does offer the prospect of real improvement and reform for the future.

Thirdly we have conducted a review of all government spending, in order to reassess the priorities of government and get the extra resources into the NHS that it needs.

That review is now completed. Its findings will be announced along with all the other settlements to Parliament in the next two weeks. Without breaching Parliamentary propriety by telling you the results, I will tell you two things. The first is that I know the NHS is under funded. I know it needs more investment. I know it must have more resources to do the job. You will see that the NHS will get the resources it needs. I give you that commitment. But I do more. The last thing the NHS needs is more money the one year and less the next. Bursts of spending followed by drought. Over the last 25 years NHS spending wildly - sometimes real terms increases of 5 or 6 per cent, then one per cent or even a real terms cut.

The settlement we announce will be a three year settlement. More than this it will offer sustainable year on year increases for the foreseeable future. I want a NHS with the confidence that its funding will allow it to plan ahead, to be creative - develop services in a knowledge that they will be there today and in the years ahead.

The new funding settlement for the long term will come however at a price. And that price is the change necessary to make money work. It is a contract to renew the NHS: investment for reform; money for modernisation. We will work with you to do it. We will listen. We will consult. We will be open. But change and reform there should be and no vested interests, no conservative instincts,

no reluctance to do things differently, should stand in the way. I believe you are on for that change. So let us see the type of things with the money and the vision to change we could achieve.

Today's problems

In many ways the problems we face today parallel those of 50 years ago. The worry about paying for a visit to the doctor has been banished. But in its place there is a new form of insecurity.

The NHS is not tailored to the needs of the hectic lives that so many people lead. We worry about waiting for appointments, worrying whether doctor's appointments will fit around work, whether the hospital will cancel the operation, whether the surgeon will be the best.

We make too little effort preventing ill health. There is a big gap between those with the worst health and those with the best. The life expectancy of those higher up the social scale - those in professional and managerial jobs - has improved more than those lower down - in manual and unskilled jobs. Inequality, unemployment and social exclusion also play a big part.

The internal market did great damage. Though it made costs more transparent and devolved power, it was expensive. It was bureaucratic. There was little co-ordination. It undermined the public service values that underpinned the NHS. It forced NHS trust to compete against NHS trust. It set GP practice against GP practice. Patients treated according to who their GP was rather than according to their medical need. Catastrophic breakdowns in the system for looking after mentally ill patients living in the community. Millions wasted on aborted PFI deals. Cervical screening failures that were not monitored or addressed.

The NHS needs more money but more modernisation too.

It may seem strange that a service that has seen so much innovation and technological breakthroughs has in many ways failed to modernise. But fifty years into the NHS we have no system for assessing the clinical and cost effectiveness of treatments provided. We have had no way of measuring what patients think of the service. Too many treatments prescribed on the basis of received wisdom instead of the latest scientific evidence. No effective or universal clinical audit system. Poor use of IT. And no arrangements for spreading good practice around.

Quality of care is patchy

And this reluctance to modernise has a cost. There are huge variations in efficiency and quality. If every trust were to perform to the level of the top quarter we could realise efficiency savings of at least 12 per cent. The number of cataract operations performed as day cases ranges from less than 20 per cent to over 95 per cent. The NHS is good and in many places it is excellent but it is far too inconsistent.

Our vision

It will take time to put right the current shortcomings. It cannot be done overnight. So let me explain what I see the NHS becoming.

First, we have to tackle the causes of ill health as well as its effects. That is not just a task for government. Developing a healthier society requires government, local communities and individuals all to play their part.

Tessa Jowell, the country's first ever Minister for Public Health, is providing a focus for co-ordinated action. It's why we were so determined to secure a European Directive to ban tobacco sponsorship and advertising and so give a lead in the fight against the

biggest single cause of premature death. Our Health Improvement Programmes will enable doctors, nurses and health and local authorities to work with local people on meeting the four national priority areas for better health: heart disease, cancer, accidents and mental illness as well as other issues such as the abuse of drugs and alcohol and teenage pregnancies.

Health action zones, healthy living centres and healthy schools will provide the impetus and resources for local communities to take practical steps to address health inequalities.

Second, spreading excellence. I want to see the NHS provide quality care whenever and wherever people go into an NHS facility or use its services. People must have the confidence of knowing that the best will be the norm - wherever they live.

How will we do that? To begin with we will improve primary care. Nine out of ten people who contact the NHS receive their treatment and care from their local GP, practice nurse or community service. We cannot be satisfied if some people can have access to an all-singing, all-dancing health primary care centre offering overnight test results, with physiotherapy, outpatients well-women clinics and a walking-wounded treatment centre on site, while others have to settle for a surgery that is open for four hours a day. That is why we are setting up Primary Care Groups. Their prime purpose is to make sure that whichever GP a patient happens to be registered with he or she has access to a network of quality local health services. And I welcome the overwhelming support that GP representatives from all over the country gave last week to the establishment of Primary Care Groups.

A crusade for excellence in every NHS service at every NHS facility just as we are demanding the highest standards in every school.

We are:

- establishing the National Institute for Clinical Excellence to evaluate new and existing treatments, technologies and drugs.

- setting up teams to help spread best practice and improve performance.

- giving the chief executive of every NHS trust a new duty of quality.

- introducing new rules to guarantee more rigorous and systematic review of the performance of every doctor and nurse.

- requiring all hospitals to publish success rates of treatments.

- establishing a Commission for Health Improvement, headed by a Director charged with checking on a rolling basis that every NHS trust is applying the highest quality and clinical audit standards.

These are radical changes to ensure that people get high quality care wherever they are treated.

And the professions know that they have to make professional regulation swifter, tougher and more open if it is to regain public support - the essential foundation on which all regulation depends. I never want to see doctors acting as if they are above scrutiny by virtue of their years training. Patients have a right to expect that the person who operates on them is up to the job. Government has a duty to ensure that they are. Never again must the scandal of Bristol

- an unforgivable failure to act on the signs of poor performance - be allowed to tarnish the reputation either of the vast majority of good and able doctors or of the NHS.

Third, Consumer service - fast and responsive and convenient. We live in a fast-moving world. Technology moves on. People's expectations change. People know that hospitals work round the clock but they still sometimes feel that the instant access, 7 day, 24 hour world that they normally live in appears to have passed the NHS by.

I am proud of the pledge we made on waiting lists. People are fed up with waiting. They wait for a GP appointment. They wait in the GP surgery. They wait for a prescription. They wait for outpatients. They wait to have tests. They wait for results. They wait for their operation. They even sometimes wait to be discharged!

That's got to end. The NHS Executive has reported to us that early indications show that waiting lists stopped rising in May and have been coming down in June. That is the first time in years. That is the result of the hard work of NHS staff. But there is a long way to go. We must do better. Our initiative to reduce waiting lists and waiting times is not a one-off gimmick. It is part of a permanent way of working that I want the NHS to embrace.

Information technology has the power to help us transform the situation. Already we are setting up NHS Direct - an instant access 24 hour telephone nurse helpline. I can announce that by the end of this financial year we will have extended it to 20 per cent of the country and by the year 2000 it will be available nationwide.

But NHS Direct as a helpline is only a starting point. In time I want to see NHS Direct become a gateway to new treatments for patients

by offering consultations, arranging prescriptions and booking hospital appointments by phone. IT links between GPs and hospitals. Booking a date and a time to see the doctor or have an operation will become routine as simple as booking a plane. Same day test results becoming commonplace.

The challenge is for the NHS to harness the information revolution and use it to benefit patients. Already there are cardiac patients who are having their heart beat monitored by phone. And the day is not far off where the internet and interactive TV will give us the convenience of home visits that can be done through technology. Paramedics at the scene of an accident will use video links to draw on the expertise of hospital specialists, so that they can provide immediate care and treatment. And if you live in Birmingham and have an accident while you are, for example, in Bradford it should be possible for your records to be instantly available to the doctors treating you.

But what I am talking about goes beyond the use of new technology. It goes to the heart of the culture of the NHS. The NHS relies on the dedication of its staff. But often, particularly at times when services have been short of money, and despite the extraordinary dedication of staff people feel let down.

You know just as I know that people remember their experience in hospital not just because of the treatment itself but the experience they had.

- Take mixed sex wards.

- Or elderly people left on trolleys in corridors.

- People on crutches standing in A and E because there are not enough chairs.
- Unpleasant food.
- Cancelled operations.
- Elderly people not treated with respect.
- Doctors refusing or incapable of explaining in simple terms the options for treatment.

None of these things mean that you necessarily get bad treatment when you are seen. But they are things you remember. And they are unacceptable in a modern health service.

Of course, there are a lot of good things to celebrate about what the NHS is doing. The imaginative way that hospitals, GPs and community services used the winter pressures money was outstanding. Rehabilitation, observation and admission wards opened up, extra weekend surgery sessions, more people cared for at home by district nurses. And it's not just new initiatives at which the NHS can excel. The nurse who holds the hand of someone while their relative is dying, the volunteer who dispenses tea to visitors, and the GP who spends hours talking through a cancer diagnosis with a worried patient are a tribute to what the NHS at its best can be.

The challenge is to make the best the norm. We need to take the founding values of the NHS, learn from the best of modern business practice and move the NHS into a new consumer-friendly, instant access age.

Partnership and co-operation - the notion that we achieve more together than we can alone - were and remain the core values of the NHS. They are the means that enable and empower staff to provide the care and commitment to patients day in and day out. But to these values the NHS can learn from other businesses and services and add a focus on performance. Clinical outcomes, efficiency targets, cost comparisons, quality audits and performance incentives are not just management jargon but important tools for helping us to improve and modernise health care.

Alongside that will come plans to get the staff we need into the NHS and try to keep them. I know it is no use having great plans to modernise the NHS if we cannot attract and retain the staff if we can't implement them. That needs more practical and tangible signs of how we value them than merely telling them what a good job they do. I promise you again that it should be a fundamental part of our vision for the future. Family friendly and employment policies, improved staff training and zero toleration of violence against staff will be part of our plan to improve the position for staff.

A lot of people say that this leap in performance for the NHS is undoable. They believe that the 50th anniversary marks the beginning of the end for the NHS. Too much demand, too little money, something has got to give. A health service free at the point of use is, they argue, not sustainable.

But such an analysis is false. No one has come up with a more cost effective system than ours. The US system with more private care results in higher costs and lower efficiency in return for the same outcome and poorer equity. We spend about half of what the U.S. does on health as a proportion of total domestic expenditure. But

our female life expectancy at birth is about the same and our male life expectancy at birth is better.

And, although demand will continue to rise - as it has done throughout the history of the NHS - the changes we are making will enable us to respond to it in more modern ways. For example, the mechanisms for evaluating new technologies, drugs, and treatments will help clinicians to know what is best to prescribe in what circumstances and help the NHS to manage new pressures and interventions rather than be driven by them. And sensible measures such as levelling up day surgery rates and reducing ineffective treatments will enable the NHS to increase its productivity and take on thousands of extra cases every year.

To help those changes there are two further elements to our reform programme.

As part of our three year funding we shall be establishing for the first time an NHS Modernisation Fund, part of the overall spending but ring fenced for modernisation. It will fund the IT revolution. It will go towards making sure that we meet the reductions in waiting to which we are committed. It will help to pay for the refurbishment of hospitals and the building of new GP premises. It will help buy new equipment. It will support the promotion of good health. It will pay for better training for NHS staff. The distribution of money from the modernisation fund will be linked to proper plans and proven mechanisms for using it. It will be money linked to results. It is investment for reform.

And to try to help that reform to take root and flourish we shall shortly be inviting applications from NHS trusts and GP practices to become what we are calling beacons of excellence. As with

beacon schools they will be hospitals, health centres, day units and surgeries that are delivering the highest standards of care or are piloting innovative practice. The beacons will receive extra financial support which they will use to help others to improve their performance. It may be that they are leading the IT revolution, have pioneered clinical governance, are running successful programmes to cut tobacco consumption and heart disease, or have re-engineered their casualty facilities to provide a wait-free A&E service. Whatever their record of achievement they will be beacons showing the way for others to follow. Again, this will be over and above normal spending but it will try to stimulate innovation and change.

This is a programme of change that is hugely ambitious. It will take time. The cynics will write it off, but then the cynics never create the future. I am offering you a real partnership to renew our NHS.

I made my reputation in the Labour Party as a moderniser. I did it to win, of course. But above all I believed in it. Modernisation for me was never about ditching traditional values. It was about breathing new life into them. I feel exactly the same about the NHS. I believe in it passionately because its values of community, justice and equality are the best values of any civilised society. It was Nye Bevan who called the NHS 'the greatest act of civilisation' any government had undertaken.

Now we have to give this great institution a future. We all have a responsibility to do it. We have a responsibility as a government to get the money in and to formulate with you the right programme of reform. You have a responsibility to help us deliver it.

Together we can do it and the next 50 years of the NHS can be its best 50 years, with many more anniversaries to come.