Universal Healthcare in the 21st Century

Rt Hon Stephen Dorrell

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Stephen Dorrell
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Biography

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Stephen is currently Chair of the NHS Confederation.

He stepped down as a Member of Parliament in May 2015. In May 1979 Stephen was elected as the first Conservative Member of Parliament for Loughborough. From June 1983 to June 1987, Stephen served as Parliamentary Private Secretary to the Secretary of State for Energy, the Rt Hon Peter Walker MP. In June 1987, he was appointed an Assistant Government Whip and became a Lord Commissioner of HM Treasury (a senior Government Whip) in December 1988. From May 1990 to April 1992, he was Parliamentary Under-Secretary of State at the Department of Health. In April 1992, he was appointed Financial Secretary to the Treasury. Stephen was Secretary of State for National Heritage from July 1994 until July 1995 and Secretary of State for Health from July 1995 - March 1997. In the 1997 General Election, he won the new seat of Charnwood with a majority of 5,900, and subsequently served as Shadow Secretary of State for Education and Employment. In June 1998, he left the Shadow Cabinet to return to the backbenches. From 2006-07 he was Co-Chair of the Public Service Improvement Group, established by David Cameron to review policy in education, health, social care and housing. From 2010 to early 2014, Stephen was Chair of the Health Select Committee.

He became a Place2Be trustee in 2012. Stephen brings a wealth of knowledge around senior government and the Department of Health.

His business interests include chairing LaingBuisson, Public Policy Projects, Dorson Group and The Network Group.

About Public Policy Projects

- Public Policy Projects (PPP) has a 20 year history of delivering events in the health, care and local government sectors.
- Public Policy Projects (PPP), chaired by Rt Hon Stephen Dorrell, offers practical policy analysis and development.
- PPP has hosted speakers including Rt Hon Matt Hancock MP, Rt Hon Jeremy Hunt MP, Andrew Gwynne MP, Simon Stevens, Lord Carter, Professor Dame Sally Davies and many other senior thought leaders.
- The network consists of senior leaders across the health, care, life sciences and local government sectors.
- PPP also advises on policy development in health, care, life sciences and local government.

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July 2018 marked the 70th anniversary of the foundation of the NHS; it prompted a flurry of commentary telling the familiar story of the foundation years and celebrating the fact that the UK was an early pioneer of the principle of universal healthcare.

Although the UK was a pioneer, the objective of universal healthcare is now widely shared and has been repeatedly endorsed by both the UN and WHO. It is an idea whose time has come, defined by the WHO as follows:

> *"All people should have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship".*

Aneurin Bevan described it more simply as "socialism in action". It is easy to understand why he expressed it in those terms, but its appeal is in fact much broader. The Economist, for example, which has been an authoritative guardian of liberal values since 1843 endorsed the principle when it wrote that "there is a principled, liberal case for universal healthcare" and that it is "sensible, affordable and practical".

The principle of universal healthcare is therefore now widely embraced, but different countries apply the principle through different institutional arrangements. This often leads political voices to claim that the differences between the different systems are more profound than they really are – with the result that there is often unnecessary resistance to applying lessons in one country which have been learnt in another.

The strength of the foundation myth in the NHS means this can be a particular problem in Britain. Public support for the NHS is a source of strength, but it can become problematic when it transfers from the principle of universal healthcare and attaches instead to the institutions of the NHS. Changing demand and changing practice mean that institutions, many of which remain largely unchanged since the 1940's, need to change; the challenge for the NHS is to ensure that while it celebrates its achievements it is always in the vanguard of change and open to new ideas and good practice from wherever they come.

That is the central challenge which faced the authors of the NHS Long Term Plan (NHSLTP) published in January 2019. While we can continue to celebrate the fact that the UK was an early pioneer of universal healthcare, we should resist the temptation to believe that other societies don't share our objectives; we should recognise the reality of shared aspirations and ensure we don't miss opportunities to learn from them.

The challenge of affordability

The most obvious issue facing all healthcare systems is the challenge of affordability. Delivery of universal healthcare against the background of developing clinical opportunities and increasing life expectancy has meant that the healthcare sector has grown consistently as a share of all economies. This growing share is often seen as a problem – and used by political voices to claim that "the model is broken". Each country has its own version of this claim, but they all focus on the rising share of the economy accounted for by healthcare spending.

This analysis misses the point that the balance of any economy will always reflect the changing needs and preferences of its citizens and the changing opportunities offered by producers of goods and services. A better approach would surely be to regard the growth of healthcare spending as a rational priority for current expenditure and focus on the implications for public policy of such growth.

The UK faces a particular version of this challenge because of our political choice to fund the NHS through a tax-funded single payer system. Our approach sharpens an unavoidable conflict between two policy objectives; it means that our desire to facilitate growth in the healthcare sector in response to citizen demand is in direct conflict with the objective of restraining the tax burden.

Although the NHS model focuses attention on the link between health spending and the level of taxation, the challenge of affordability is extensively discussed in all countries. The debate in the USA, to take the extreme example, focuses on the fact that health and care services account for approximate 17 per cent of the US economy despite the fact that, even at this level of commitment, over 10 per cent of Americans are still uninsured, with the result that the USA is one of relatively few OECD countries which does not offer its citizens universal healthcare.

Most European countries achieve universal coverage at a cost of between 9 per cent and 12 per cent of their economies, but the common concern in virtually all countries is the belief that they face a crisis of affordability.

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The challenge of value

Facilitating growth of total spending in this key sector is however not the only public policy challenge. Policy makers are interested in value created as well as the total level of expenditure. Although the US economy supports the highest per capita spending on healthcare services in the world few would advocate adoption of the US policy framework, even if it delivered universal coverage, because there is clear evidence that it delivers poor value when outcomes are related to costs and compared with equivalent information from other systems.

It is not simply a matter of equitable access to services – although access is a core principle of universal healthcare. Value is created through improved life chances, not maximised activity. Modern understanding of the causes of ill-health, coupled with the opportunities to change outcomes created by new technologies, represent a challenge to policy makers to follow up all such opportunities, rather than simply facilitating additional activity by traditional models of healthcare delivery.

This requirement to respond to new opportunities to improve health outcomes does not make health policy different from other fields of policy; on the contrary, it underlines the fact that all policy choices should be judged by the outcomes they deliver. It also draws attention to the fact that public health objectives lie at the heart of many policy choices and reinforces the obvious point that successful societies are constantly changing in response to a wide range of influences. It is a necessary and healthy process and it is a process in which the health and care sector should be a leader not a laggard.

Impact of new technologies

The key driver of change in all advanced economies is the development of new technologies. Indeed, it was the capacity of technological development to deliver better outcomes and improved life chances for citizens which was the transformative change brought about by the industrial revolution.

Two technologies in particular drive this process in the health and care sector. The first is digital connectivity which offers opportunities for conventional operational improvement at the same time as “artificial intelligence” and “big data” offer prospects for more efficient policy interventions. These opportunities arise at the same time as pharmaceutical science is creating more personalised medicines, based in part on a developing understanding of genetics.

All these developments offer the promise of significantly better outcomes for citizens in every country, but they also demand disruptive change to institutions and working practices which command high levels of public trust. This requirement for disruptive change represents a significant political and management challenge, and nowhere is that more true than it is in Britain.

Digital technology

The opportunities created by digital technology reflect opportunities which have affected every sector of the economy. Digital connections allow service providers to link previously discrete episodes into a continuous and interconnected process which both reduces cost and increases effectiveness. Implementing these changes in the health and care sector challenges existing service structures in the same way that structures in other service sectors have been challenged; health and care services have been slow to respond and need to commit both to a step change in investment in information systems and also to organisational changes to realise the opportunities created by new information systems.

Digital technology also allows us to look beyond “doing things better” to “doing better things”. Modern data tools allow policy makers to identify patterns and trends associated with the causes and early onset of diseases such as diabetes, dementia and cancer, but current structures are ill-designed and ill-equipped to take advantage of these opportunities. Public services need to “make it easy to do the right thing”, rather than persist with structures which rely on dynamic individuals to find work-arounds within structures which were designed for a different purpose in a different world.

Both these challenges point in the same direction – and it is a direction which is already familiar in other sectors. The key point about the new technology is that it creates networks which allow linkages between different actions to be analysed and understood. The challenge for service providers, in the health and care sector as in other sectors, is to redesign their services in ways which will allow them to respond effectively to the connections and analysis which digital technology can provide.

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Pharmaceutical science

The changes to service delivery which will be required to take full advantage of the development of pharmaceutical science are at least as profound as those required to benefit from the opportunities created by digital technology. Indeed, at heart they are the same, and they will require those involved to move beyond simple transactional relationships and build partnerships which focus independent entities on the achievement of a common purpose.

This requirement is a fundamental challenge to the traditional relationship between the pharmaceutical industry and the healthcare system. In that model the industry invests in the development of new compounds which are tested in clinical trials before being approved by regulators and launched for general use. Commercial success relies on maximising sales to a global market at prices which allow the company to generate profits before the end of patent protection. The instinct of the healthcare system is to hold the company at arm's length and negotiate the lowest possible price for supply of the new product.

There are several problems with this model. The most obvious is that it regards each new compound as a discrete development and does not sufficiently recognise the incremental nature of scientific progress. This has the effect of inviting a healthcare provider to assess the value of a specific incremental advance rather than the value of a long-term development and it also creates the risk that a provider falls behind best international practice, with the result that it no longer provides a base case for assessment of the next generation of pharmaceutical advance.

To avoid these risks the pharmaceutical industry has in fact developed closer relationships with care providers in areas of shared therapeutic interest than the traditional transactional model would suggest. Care providers increasingly work with pharmaceutical companies to target their research and develop new therapies which are then subject to clinical trials.

These trends are reinforced by the developing importance of treatments for rare conditions. The key point about rare conditions is that while an individual condition may be rare (defined as affecting fewer than 5 in 10,000 people), there are up to 8,000 known rare conditions and up to 250 new conditions are described in the medical literature every year. These trends will gather pace as improved genetic understanding leads to an increasingly personalised understanding of disease which will in turn challenge head-on a pharmaceutical business and regulatory model which assumes that production and distribution of medicines is a mass-production business.

Just as digital technology is challenging traditional definitions of public services and requiring service providers to integrate their activities to improve outcomes for individuals, similar challenges are being posed by these developments in the pharmaceutical industry. In a world where medicinal interventions are likely to become increasingly personalised (in the current terminology "rare") it will be necessary to redefine the relationship between the care providers and the medicine producer. Pharmaceuticals is moving beyond mass-production and that will require a different relationship between the industry and both care providers and individual citizens.

Shortcomings of the transactional model

The challenge facing public policy is the requirement to reconcile these conflicting pressures in a way which commands public support. Concerns about affordability often lead commentators to conclude that the circle can only be squared by extending the principle of co-payment (i.e. patient charges) to ensure that the revenues required to finance a growing sector are drawn in part direct from citizens, rather than relying exclusively on continuous increases in revenues funded by the taxpayer.

The conventional political argument against this approach is that it would meet intense opposition and is therefore beyond the realm of practical UK politics. But there is a more fundamental reason to reject the insurance-based model. It is a consistent theme of this paper that healthcare is not a series of unrelated transactions. Although many episodes of ill health are unpredictable, the majority of healthcare expenditure relates to demands that are predictable and lend themselves to prevention or early intervention. It is therefore an inadequate basis for health policy to regard ill-health as an unpredictable risk where the main function of the insurer (whether in the form of social or state insurance or the commercial sector) is to provide financial support to those for whom the risk crystallizes.

The alternative approach which the UK is well placed to develop starts from the assumption that it should be a general objective of public policy to maximize the opportunity for citizens to lead healthy and fulfilling lives. This approach does not necessarily mandate collective interventions in the private space ("the nanny state"), but it is based on the view that those who are responsible for public policy on issues such as food, environment, education, employment, planning, transport and housing, as well as social care and the networks of civic society, should all recognize the impact of their decisions on the health of citizens (i.e. "public health") and coordinate their actions in pursuit of their declared policy objective.

The fundamental weakness of the insurance model is that it assumes health is a discrete subject which can be separated from the rest of public policy. The truth is the opposite; public health objectives should lie at the heart of public policy and inform all government decision making at both the local and national level.

The UK policy context

The foundation myth of the NHS is that the taxpayer-funded single payer system is the only way of delivering the objectives of universal healthcare. In fact, other societies have found other ways of delivering universal access to high quality healthcare, at the same time as being more successful than the UK at allowing the health and care sector to grow in response to the wishes of their citizens.

None have yet developed a convincing answer to the challenge of shifting the policy priority away from providing high quality reactive care to maximizing opportunities for pre-emptive actions which support fuller, healthier lives for citizens – in other words which focus on outcomes rather than outputs.

The UK has both big advantages and disadvantages as it grapples with these issues. The NHS was a pioneer of universal healthcare and is a relatively efficient provider of healthcare services; furthermore, the publicly funded single payer model should provide the opportunity both to create greater transparency and accountability across NHS services and to achieve greater integration with other public policy interventions.

The institutions of UK public decision making are however extraordinarily maladjusted to take advantage of opportunities for integrated interventions and, in many cases, represent powerful impediments to improving health outcomes for citizens. Furthermore, repeated reorganisations of the NHS have discouraged any moves in this direction and encouraged organisations to seek internal solutions to the issues facing them.

This tendency towards silo-thinking has meant that NHS organizations have not maximized the opportunities for external partnerships, including those outside the NHS. Too often the instinct has been to seek solutions within the organisation, or to confine outside relationships to other NHS organisations. This approach runs the risk of creating a "closed room" within which the NHS avoids considering alternative approaches but, even more importantly, it effectively eliminates consideration of the wider context of health policy.

Integrated Care Systems

This is the challenging background against which the NHS LTP for England makes the commitment that "by April 2021 Integrated Care Systems (ICSs) will cover the whole country".

At its most ambitious, the concept of an ICS is a potentially transformative answer to some of the challenges facing health policy both in the UK and beyond. Each ICS is intended to be a partnership between the NHS and other stakeholders including local government, the independent sector and the third sector. The commitment of NHS leadership to build a more collaborative approach at local level is key; it reflects recent developments in the structure of local government, and it offers the prospect of developing a focus on outcomes and away from the excessively transactional approach which has grown up in recent years.

Part of the challenge facing each ICS is the requirement to reconcile this stated objective of achieving more collegiate working at a local level within and beyond the NHS with the instinct of the NHS to develop blueprints which are then "rolled out" as national initiatives. The dilemma is well illustrated in the approach to primary and community services care reflected in the NHSLTP and the five-year framework for GP Contract Reform (GPCR).

The NHS LTP makes a commitment that the resources available to primary and community services will grow faster than resources for the NHS as a whole which represents a commitment to develop a ring-fenced growth fund worth

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£4.5bn by 2023/24. This commitment challenges the natural tendency for both human and financial resources to gravitate towards the acute sector and could create the opportunity to develop more flexible programmes at a local level based on geographical circumstances and priorities.

That is not however the approach taken by the GPCR, which is significantly more prescriptive. It sets out detailed proposals which link additional resources for primary care firstly to additional staff within the core GP contract (£978m by 2023/24) and secondly to specific "enhanced services" within a new contract with Primary Care Networks (PCN's) (£1,799m by 2023/24). The intention is that every GP practice will be part of a PCN and that PCN territories will be the basic building blocks of each ICS. Most PCNs will be GP led networks of existing GP practices contracted under a nationally mandated formula by slimmed down CCGs, working within the ICS framework.

This approach is reflected, albeit in a somewhat less prescriptive form, in the range of service objectives set out in the NHS LTP itself. Most ICSs, supported their clinicians and local communities, would probably endorse most of the service developments set out in the NHS LTP, but many may wish to flex timescales and priorities in the light of local circumstances.

It is often argued that the effectiveness of the NHS in England suffers from the effect of "fragmentation", implying that a once cohesive system has been undermined by a process of fragmentation. The truth is more complex and is as much the result of history and culture as it is of legislative meddling. The most debilitating "fragmentation" is the belief that health policy is primarily concerned with the treatment of illness.

Health policy needs to address the social determinants of health as well as manifestations of ill-health, but that requires the NHS to engage more fully than it has in the past with the full range of organisations which serve each local community. It is the ability to look across the range of public services in a community and respond to local priorities which will determine whether ICSs are successful. The important question is not which agency delivers the service but what outcome is delivered; if an ICS is not willing and able to make these choices it will quickly be dismissed as simply another tier of NHS management.

NHS and Social Care Funding

The importance of this principle is further illustrated by the links between decisions about NHS and social care spending. As part of the commentary to mark the 70th anniversary of the foundation of the NHS, the Government announced a new commitment in July 2018 to increase current NHS spending by £20.5 billion per annum over the period to 2023/24. That commitment represented a substantial taxpayer commitment at a time when the outlook for UK tax revenues was more than usually uncertain, but it provides a salutary illustration of the danger of looking at the NHS funding in isolation the rest of public services.

An analysis by the Institute for Fiscal Studies (IFS) and the Health Foundation published in 2018 showed that the average real terms increase in NHS resources over the previous 20 years had been 4.3 per cent per annum (6.0 per cent per annum between 1997 and 2010 and little over 1 per cent since 2010). The public spending profile in the social care sector is even more pronounced where the average real terms increase of 5.7 per cent per annum in the first decade of this century has been followed by a reduction of 1.5 per cent per annum since 2010. Against this background the authors of the report concluded that annual increases of 4.0 per cent each in both NHS spending and social care spending were required if health and care services were to be maintained even at their prevailing level.

The Government's announcement represented a commitment to 3 per cent real terms growth for the NHS which fell short of the 4.0 per cent calculated by the IFS report, but the most important policy omission is that there was no parallel commitment to develop social care. Important trends are developing within social care which mean that the balance of social care spending is shifting in favour of working age adults whose life expectancy has been dramatically increased in recent years; the perverse consequence of this welcome trend is that care for older people is taking a falling share of a falling social care budget at a time when demand for care services for older people is rising faster than ever before.

An ICS which is not able to address this funding shortfall in social care will not be able to deliver its objectives. That will have an economic impact, as opportunities are lost to avoid hospital admissions or facilitate discharges, but the more important consequence is that public services in the community will be failing to take opportunities to improve the health outcomes of its citizens.

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The role of Local Government

One of the developments envisaged in the NHS LTP is an explicit role for Local Government in decisions made by an ICS. At the most basic level this is necessary and overdue because local government is responsible for social care. More fundamentally, however, local government is also responsible for a wide range of other social determinants of health outcomes, and if an ICS is to deliver its objectives those responsibilities need to be at the table. Furthermore, local government should have a powerful voice not simply as a service authority, but also as the voice of the community. Health and care services are an important part of the fabric of every community and it should be unthinkable that decisions would be made without engaging with the elected representatives of the community.

Conclusion

Questions about the role of local government go to the heart of the issues addressed in this paper. At the root, the issue is whether health policy is simply a form of transactional insurance, which provides protection against unpredictable risk, or whether it should be engaged and committed to improved health outcomes for all citizens.

A fully developed ICS will focus on outcomes and, by implication, inequalities. It will recognise that the objective of improved outcomes for all citizens requires a different relationship, both between service providers and between the citizen and the state. If they take root, ICSs will allow the UK, once again, to develop an approach to health policy which sets a precedent for others to follow. They will do so because a fully developed ICS offers a convincing answer to the challenges of affordability and value which are faced by all healthcare systems.

They do so because they allow resources to be used in ways that reflect local priorities and focus attention on outcomes. A fully developed relationship with both Local Government and civic society offers a real prospect of a less transactional relationship between citizens and the community in which they live – which can open the door to greater emphasis of prevention and support, and a reduced reliance on crisis management.

It is a great prize, and it would be genuinely innovative. The immediate challenge is to ensure that the ingrained habits of 70 celebrated years of NHS history are not allowed to disrupt the development of a formula which can secure the benefits of universal healthcare for the next 70 years.

Questions to ask:

- Is it a problem that health and care spending account for a rising share of most countries' economies?
- Does the UK reliance on tax funded care represent a particular problem?
- What are the principle challenges to the traditional health service model posed by new technologies – digital and pharmaceutical?
    - Shifting towards prevention and early intervention
    - Personalised medicine
- Will politicians authorise the optimum service models?
- What role should private sector enterprises (digital and pharma businesses) play in service model change?
- Is it right to shift from a transaction model to a more engaged approach?
- Is an Integrated Care System a convincing answer to the affordability and value challenges?
    - Is the NHS open to new partnerships?
    - Can the NHS work more closely with local government?
    - Does local government provide effective local accountability?
- How can NHS national accountability be maintained in a more localised service?
- What is the right answer to the Social Care Funding Challenge?

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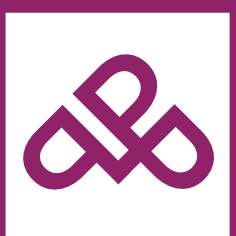
Public Policy Projects would like to incorporate your thoughts to this paper – your views, thoughts and ideas will help deliver the actionable insights necessary to embed a 21st Century universal healthcare system.

Please can you contact Managing Director, Ben Howlett at **ben.howlett@policyprojects.com**



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