

**Speech by the Rt Hon Patricia Hewitt MP, Secretary of State for  
Health, to the London School of Economics, London,  
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**Introduction**

The NHS is under attack.

It is under attack from those who've never believed in a comprehensive NHS, free at the point of use, and those who don't believe that the NHS is sustainable. Mr Lees, speaking for Doctors for Reform, said that their ambition was, and I quote, "to introduce funds not raised by tax-based revenues. We are very drawn by social insurance and other models." And although the BMA itself is clearly committed to the founding principles of the NHS, a resolution at its GP Conference this month called for: "resources for routine care outside core hours should be partially or wholly provided by a fee charged to the patient."

I passionately believe that they are wrong, and this morning I will set out why.

**Dystopia**

Let me begin by standing ten years in the future and imagining the kind of NHS we could then have.

A future where those calling for rationing and co-payments have had their way.

Where the only guarantee of treatment is to a basic ‘core’ of NHS entitlements.

Where a £20 charge for convenient GP appointments was just the prelude to means-tested co-payments for all GP appointments, A&E attendances and hospital admissions.

Where you *can* have drugs and treatments that aren’t included in the basic package ... but only if you pay extra.

Where everyone who can afford it – and some who can’t – take out private health insurance ... and the inadequate resources available to the NHS are further diminished by the subsidy offered to those who go private.

## **Destruction**

The people who propose co-payments and top-up fees are attacking the fundamental principles of the NHS.

Firstly, “an NHS available free to all, based on clinical need, not ability to pay.” That principle – which makes the NHS the fairest health service in the world – is not some relic of war-time solidarity: it is even more relevant in the face of 21<sup>st</sup> century science. A system based on insurance and patient selection will fail in a world where we can forecast disease by analysing a baby’s genetic make-up.

Private insurance works on uncertainty and shared risk. As science removes uncertainty, private health insurance removes its risk by either charging more or excluding people – that’s how it works. Only the super rich will escape this blight – look at the United States.

Secondly, “an NHS funded by all of us through taxation.” The NHS exists as a social compact between the young and old, the rich and the poor, the taxpayer and the non-taxpayer, the well and the sick.

The NHS is primarily paid for by working people. It’s used primarily by the very young, the old and those without salaried income. If that trust breaks down - if young, working people don’t think it will be there for them - they will withdraw their support and their willingness to pay the taxes required to maintain it – thus undermining the foundation stone upon which the NHS is built.

That is why we need an NHS that the patients love, the staff are proud of and the public trusts.

## **Saving the NHS**

In 1997 we said we had 24 hours to save the NHS.

Without a change of government, the NHS would have withered and weakened and with each year of neglect the case for scrapping it would have been made stronger.

Instead, we put the NHS into intensive care, saved it from 18 years of Conservative neglect and, over the last 10 years, reversed that decline.

It's involved many difficult decisions and immensely hard work for the staff of the NHS, but the reality now is that no political party, whatever its real instincts, would dare to fight an election openly saying – as the Tories did at the last election – that they would pay for people to leave it.

So now we must build an NHS that can thrive in the face of today's challenges – huge challenges that face every health service in every developed country.

## **Challenges**

As the population ages, the number of people over 65 is set to rise sharply. Older patients with long-term conditions have a right to expect the NHS that they have paid for to be there for them.

As technology and innovations progress, we are able to do more for more people – driving up costs. Greater efficiency will come, but the ability to do more at greater cost always seems to overwhelm the ability to do the same at lower cost.

As our lifestyles change, lifestyle diseases, like diabetes, are occurring in people at an ever younger age. When Professor Ian Gilmore, president of the Royal College of Physicians, began practising, cirrhosis of the liver was a disease of sixty-year-olds - now he diagnoses patients in their 30s regularly.

As people become better educated, work harder, live longer – even as the NHS improves – they demand more from the service and more from how

the service is delivered. People want quick responses, information on new developments and access to services when it suits them, not when it suits the providers.

## **Efficiency**

In England this year, we will spend over £90bn on the NHS, up from £34bn in 1997. That record investment helped to save the NHS after it had been left behind by the developed world.

Today, despite the difficult decisions needed to restore the NHS to financial balance, over nine out of ten recent patients tell us they had a positive experience of their stay in hospital. They can see that the NHS is better than even 12 months ago.

But the public as a whole is not yet persuaded. Those who haven't experienced the changes first hand aren't convinced they are getting value for the extra money they've contributed. And they are right: there is still more to do before the NHS everywhere achieves the levels of efficiency and effectiveness that the best do already and that are essential if we are to cope with these huge challenges.

But at some point in the future, perhaps in ten years' time, the nation will feel that it needs to make another step change in health spending. All the evidence shows that as individuals get richer they choose to spend a larger proportion of their income on healthcare, and so do countries as a whole.

So the question will not be *whether* we are going to spend more money on healthcare, but *how* are we going to spend more money on healthcare. Will it go collectively into the NHS through taxation again, or individually into co-payments and private insurance?

The answer depends on whether the public as a whole believe that the NHS can spend their money effectively and whether they trust the quality of the service that the NHS offers.

There is no doubt that recent years have left bruises, particularly upon staff morale, but also upon public confidence.

So how do we rebuild confidence in the NHS and persuade the next generation it is still worth investing in?

## **Independence**

For a growing chorus the answer is “independence”.

Stop the changes. Stop political interference. Set the NHS free.

Give it an independent board and let it get on with the job.

It’s a seductive idea.

Surely the NHS is more capable of managing itself than the government?

Let’s just think about this.

Start with size and scale. The NHS in England will spend over £90 billion this year.

If the NHS was a country, it would be the 33rd biggest economy in the world, larger than new European Union transition economies like Romania and Bulgaria.

Would the Prime Minister of such a nation seriously propose today to take the entire economy and put it under a single independent board, every organisation in the hands of one owner, run as one entity?

Of course not. The NHS is four times the size of the Cuban economy and more centralised. That is part of its problem. And the problem can't be solved by proposing that a modern health service be run like a 1960s nationalised industry.

Putting a doctor, a manager or a patients' champion at the head of an independent NHS board might be more popular than having a politician in charge, but as soon as the Board started making difficult decisions the attraction would wear off and the public would rightly ask: "What's the difference?"

Supporters of NHS independence cite the success of Bank of England independence. But just take a second to think about that.

The Bank of England has the independence to make one critical decision within a framework set by the government - not responsibility for every part of the economy.

The terms of the current debate about independence are a red herring. The real issue is not “independence or no independence”, but “what kind of independence?”

As Gordon Brown said only a few days ago, “What you want is the maximum local autonomy for your doctors and consultants and nurses and managers who are getting on with the job on a day-to-day basis.”

When the NHS was founded nearly 60 years ago, it was fashioned by necessity on the model of the times – centralised and top-down.

Nye Bevan’s phrase: “If a bedpan is dropped on a hospital floor in Tredegar, its noise should resound in the Palace of Westminster”, may have haunted Health Ministers ever since, but at the time it reassured people. A centrally governed NHS was the right system for its time because it delivered the British people from fear of illness.

However, the structures that were right in the 1940s are not right today. The structures that were right in the 1960s – when the model for the district general hospital was defined and planned – are not right today either.

### **Neither Monolith nor Market**

For the NHS to succeed in the 21st Century it must be neither a monolith nor a market.



It must not be a Soviet-style, centralised organisation, where information flows up and orders flow down, either from Richmond House or from an independent board.

That model is hopelessly out of date, incapable of providing the personalised, responsive care that people rightly demand these days; incapable too of both the speed of innovation and the scale of efficiency that are essential in modern healthcare.

And it can't be a US-style, free market either that leaves millions of people without even basic health insurance and millions more inadequately protected.

Instead, a modern NHS must move from a public sector monopoly to a truly patient-led public service.

This means doing more than changing the relationship between minister and senior managers, it means transforming the entire relationship between the NHS and the public; creating a system that is held accountable by the public, with politicians playing their appropriate role.

### **The steps taken so far towards independence**

Despite the myth of ministers controlling every local decision, we have already made taken significant steps towards creating an independent, self improving NHS.

In 1999, we started to appoint the first independent National Clinical Directors, or Tsars. These senior clinicians brought together the most respected clinical and patient experts to create National Service Frameworks – best-practice guides based on sound independent clinical evidence. The public and NHS staff alike knew what they should expect in areas like mental health, cancer and heart disease.

The same year, Alan Milburn created the National Institute for Clinical Excellence. It took the power to determine what drugs and technologies the NHS should use away from politicians and placed it in the hands of clinicians – and is now the envy of the world.

NICE has approved, in whole or in part, 36 of 41 cancer drugs it has appraised – it has said no to just 5. But remember that each time NICE – after very careful, independent evaluation – decides not to recommend a particular treatment, we get another chorus of demands for political interference.

Eight years ago, we established the Commission for Health Improvement, now the Healthcare Commission, and the Commissions for social care and mental health – together, soon to become OFCARE.

We made them responsible for setting standards, inspecting and reporting on every hospital, mental health service and social care provider in England. Again, wholly independent of government.

In 2004, we established NHS Foundation Trusts - now 67 of them, and many more to come - independent of Whitehall, accountable to their members and making their own decisions on how best to serve their

patients. And it's worth recalling that the two main opposition parties, now so wedded to independence in principle, actually voted against our policy of independent foundation trusts in practice.

Has this transparency – this independence – undermined public confidence in the NHS?

In the short-term, possibly yes.

It has revealed what was previously hidden by professional autonomy and public sector monopoly – and it has provided grist to the lobbying and media mill.

Any tabloid will always be able to make a front-page headline out of “50% of hospitals are worse than average”!

Were we wrong to do it?

No.

If we are going to build trust in the next generation, we will only do it by meeting their expectations. And in the internet age, transparent information is not only a powerful spur to improvement, it is part of what the public expects: as a patient, to have staff take the time to explain to me my condition and my treatment options, but also as a citizen, to know what is going on and to get involved in collective decisions.

**Routes to Independence: Centralisation**

But it would be foolish to pretend that we hadn't also introduced more centralisation, more top-down direction, more command and control.

We did it through national targets to make the NHS address patients' number 1 priority – unacceptably long waits for treatment: 18 month and sometimes two year waits for life saving operations, 24 hour waits on an A&E trolley.

The fact is that without targets, the NHS would not have seen the transformation of A&E services, the dramatic fall in waiting times or the thousands of extra lives saved over the last five years.

But treatment for the NHS when it was in intensive care is not the same as the treatment it needs when it is beginning to thrive.

Targets can deliver good, but they can never create world-class. As Sir Michael Barber, the Prime Minister's former chief adviser on delivery, said: "flogging a system can no longer achieve these goals: reform is the key."

I've repeatedly argued that national targets are inevitably crude. They risk distorting clinical priorities and damaging staff morale. And the top-down performance management that goes with them leads the NHS to look upwards to Whitehall, rather than outwards to their patients and local communities.

But the alternative to top down targets is not simply to hand the NHS to an independent board.

## **Reforms**

The alternative is to hand power to the patients, their advocates – crucially, GPs and others in primary care - and the staff.

And that is precisely what our reforms are doing.

## **Elements of the reform programme**

There are four elements to our reform programme: choice and commissioning, plurality of providers, quality regulation and financial discipline. Together they are transforming the NHS from a top-down bureaucracy to a bottom up, self-improving organisation.

Despite what critics say, our reforms are not about creating a free market or sacrificing collaboration in favour of competition.

The heart of the NHS, and the heart of the new, diverse NHS will always be collaboration between professionals around the needs of the patient. That is why we have placed a duty of collaboration on all providers in the NHS family and why, in the future, a key measure of the quality of care given by every provider will not only be performance, but how it partners with the rest of the health service.

Our quality standards for cancer, stroke, heart disease, mental health and so on, all stress the importance of the patient pathway. It is important that

patients should be able to choose a pathway that suits their personal needs, not be exposed to “pick and mix” medicine. These standards will continue to be an obligation on all providers and commissioners, defining what patients can expect, wherever they are in the country.

But these rules should not be a blockage to innovation and change.

Primary Care Trusts have already been given the authority and money to develop and commission services around local needs, meeting national quality standards, but not locked into historic practice.

They need to work with their GPs to devolve decision making and make Practice Based Commissioning a tool for transforming services for patients.

PCTs and practices have a unique opportunity under the reforms to transform care for their communities. That means providing services closer to home where that is safe and appropriate, but also centralising care at a specialist hospital when that is best for patients. And we will hold services taken out of hospital to the same quality standards that applied when they were in hospital.

But alongside regulation and commissioning, we also know that some competitive pressure in the NHS creates startling results for patients. A recent survey of hospital chief executives conducted by the NHS Confederation showed that patient choice was the number one issue on their minds. I can think of no greater sanction against poor services than allowing patients to vote with their feet.

I'll never forget, when I became health secretary, I heard from a young woman badly injured in a road accident who had been told by a London hospital that she'd have to wait more than 12 months for an MRI scan.

As a result, I extended choice to patients who'd been told they would have to wait more than 6 months for MRI and CT scans. You probably never heard about that; it was never advertised and never needed to be. The prospect of patient choice miraculously brought the waits down. In January 2006, there were 5,675 people waiting more than 6 months for MRI or CT scans. By April 2006 that number had plummeted to 1,031 and in April 2007 it was just 24.

Since January 2006, all patients have had a choice of at least four hospitals for their elective surgery. We have now extended this through the Extended Choice Network. The rapid growth of the network shows that the independent sector is prepared to compete with the NHS on a level playing field, carrying its own risk. By July, there will be around 180 foundation trusts and independent providers in the Extended Choice Network, available for patients to choose from.

As our acute hospitals improve and more become Foundation Trusts – around 100 by the end of this year – the choice between independent and NHS becomes a misnomer. All of these are NHS services, managed independently from the Department of Health and free at the point of use. So we're moving even faster to offer patients needing elective surgery the free choice of any hospital or clinic in the country that we promised in our 2005 Manifesto.

If you look ahead ten years, it is quite unthinkable that the NHS – the kind of NHS that we would all want to see – could be saying to patients: “you can only go to one GP practice, or one hospital or be given one appointment that may not suit you.” So it is time that we stopped arguing about the principle of choice and got on with extending the practice, not just choice of hospital or GP practice, but which specialist and what kind of treatment.

And finally on the reforms, I must just mention money. The NHS has delivered spectacular productivity improvement in the past year – a marked increase in the number of day case procedures, for instance. I know that there have been tough decisions around cuts to training budgets and deferred developments, but underneath all that the NHS treated more patients, more quickly, with better outcomes and higher patient satisfaction than in previous years. And almost nothing else will offer staff more independence and do more for morale than escaping from the deficits and taking control of their organisation’s future.

## **Values**

So we have delivered a radical reforming programme, and the NHS is beginning to look very different.

But as we provide greater independence and autonomy, and introduce more members to the NHS family, we need more than regulation to bind them together.

If providers are more autonomous, what values do we need to avoid fragmentation?



If decisions are more devolved, how is the NHS as a whole accountable to the public?

Staff fear that new providers are a threat to public service values, that using the private sector means privatisation.

The public fear that an efficient NHS means putting money before patients, and that local autonomy means a postcode lottery of services.

We need to confront these issues openly.

I have seen some hospitals telling consultants not to talk to GPs about new approaches to treating patients in the community: exactly the kind of fragmentation staff fear and which would be hugely damaging to patients.

I have made it clear that this type of behaviour is unacceptable and a statement of values – based on *The NHS Plan* – is to be included in all future contracts with anyone who provides services to the NHS.

But deeper work is needed.

It feels unfair that, if you are a cancer patient, you will get one drug in one part of the country but not another.

It feels unfair because it *is* unfair. It undermines people's trust in a *national* health service.

It is precisely why we said NICE's evaluations should be implemented within three months and why getting best value for every penny is so vital.

But not everything can be a NICE recommendation. Local health communities need the room, and the resources, to deal with local priorities as well.

A shockingly high level of coronary heart disease in one community or unacceptable levels of teenage pregnancy in another means we must leave room for clinical discretion.

We need to tackle the difficult issue of which decisions are made locally and which are made nationally.

We need to help organisations and staff balance competition – which will sometimes be appropriate and, as we've seen, give patients better care – with the co-operation that is essential between many different providers around the patient pathway.

And I believe the next step forward should be to involve staff and patients in developing a new statement of NHS values that could then be enshrined in a new NHS constitution.

## **Accountability**

This debate on values also needs to consider the issue of accountability.

Part of the chorus for NHS independence comes from managers and other staff who simply want to get on with making decisions themselves – for instance, about which services go where.

I have no doubt those decisions are best made locally – and made with effective public involvement. Sometimes the local NHS does that extremely well, but not always. When local issues end up nationally with Ministers, it's all too often because there hasn't been the effective engagement and trust built between the local NHS and local people.

There is a real opportunity now to strengthen local accountability, to overcome that democratic deficit, to give patients greater collective voice as well as individual choice.

The new Primary Care Trusts have a powerful opportunity to work more closely with their Local Authorities. If we are to focus on the health of the nation and not just its sickness, partnership between health and social care is an obligation, not an optional extra. Together they can involve local residents in agreeing priorities, reshaping services and transforming people's health, using Local Area Agreements to make clear promises on which they can be held to account. Merseyside, for instance, has created a new kind of local democracy through its *Big Health Debate Live!*

Already we can see local councillors, through Overview and Scrutiny Committees, playing a much fuller part in shaping health services for their area. Increasingly, the partnership involves joint commissioning, joint appointments or pooled budgets. In Knowsley, where several years ago both the council and the local NHS were amongst the worst in the country, they took an even more dramatic step and merged their

commissioning and provision. In future, we may see some local PCTs and their residents decide that some PCT board members should be directly elected. But developments like this must not be imposed from above: they should grow organically as the PCT and the council become more confident in their own roles and the co-operation between them.

### **And where do we need to go next**

I spoke earlier about how we have already created new forms of independence for the NHS.

Whilst I don't believe that an independent board is the way forward, there are other decisions that could be made independent of government.

Where hospital reconfigurations are concerned, we already have an Independent Reconfiguration Panel – led by clinicians – to advise the Secretary of State on cases where no local agreement can be reached. We should now consider separating it from government, so that Overview and Scrutiny Committees could refer a proposal directly to the Panel rather than to the Health Secretary. The Panel would have to weed out the weak referrals, which the Department does for them at the moment, but I'm sure they could cope! But in turn, Panel decisions should be binding – thus encouraging the local NHS and the Overview and Scrutiny Agreement to reach agreement and avoid referral.

We should also consider Bank of England-style independence for the Advisory Committee on Resource Allocation (ACRA), which determines the funding formula for PCTs. The Opposition health spokesman seems

convinced that I sit with a slide rule calculating individual PCT allocations. The reality is that the secretary of state sets the goal for ACRA – and with a Labour health secretary, that goal is to secure equity and reduce health inequalities. That decision is, properly, the responsibility of the elected government. But ACRA then provides the exhaustive statistical analysis that no Minister could, or should, try to get involved in.

## **Conclusion**

As we secure the full benefits of the reform programme, and give patients and staff more control and greater autonomy, we can save the NHS for another generation.

We can embed the values of the NHS in a way that builds the confidence of staff and public alike.

Stand in the future again: a very different future from the one I sketched out at the start. The care you need is personalised to you, available when you need it, free at the point of use. It is provided by a range of organisations, some with staff directly employed by the NHS, some of them working in social enterprises and the not-for-profit sector, others working for profit making companies. You will choose not only where and when you get your care, but will be a fully informed and empowered participant in decisions about your care.

If you want to say, “Doctor, what do you think I should do?” that is a perfectly reasonable way of exercising your choice. But, if you want to

make your own mind up, the NHS ensures that only safe and good quality choices are made available to you.

Waiting will be a thing of the past, and planning your treatment will be everyone's expectation.

The NHS will have driven up productivity and quality and maintained the confidence of the public, who continue to pay their taxes to maintain a comprehensive service free at the point of use.

The NHS will ensure that new leading edge treatments are instituted quickly for all patients who can benefit. It will also take tough decisions about what is a good use of the taxpayers' money, and this will be transparent. If people want to spend their own money on a million to one chance, that is for them to decide, but where the NHS draws the line it will need to have general public acceptance.

So, personalised, caring, leading edge and fully engaged in the local and national community – these are the challenges that the NHS must meet if it is to maintain the confidence of the public for another generation.

We will succeed not by giving the NHS an independent board, but by giving patients and staff the tools and autonomy to get on with the job.

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