A Clean Bill of Health

Policies on Paying for NHS and Social Care in England and Wales

Policy Paper 36

Contents

Summary

Liberal Democrats believe a key objective of public policy should be to help people to enjoy good health, to be able to work, live independently, and have a rewarding social life. This overall objective can be broken down into three components:

- Avoiding illness where possible.
- Treating illness or injury where they occur as effectively as possible on the basis of clinical need.
- Assisting those with long-term illness or disability to lead the fullest possible lives, and to remain in their own homes as long they choose.
- Enabling people wherever possible to be able to contribute to society, whether through paid work, volunteering or caring.

To help achieve this objective, we have identified certain priority areas within the NHS and other public services for extra investment:

- General NHS Staffing Shortages.
- Cancer Treatment.
- Treatment of Cardiovascular Disease.
- Mental Health Treatment.
- Preventive Actions.
- Restoring Dental Services.
- Long Term Care.

To address the chronic underfunding of the NHS we would:

- Raise the share of GDP spent on the NHS to at least average EU levels within five years.
- Spend money on the NHS rather than tax cuts.
- Strengthen the work of the National Institute of Clinical Excellence.
- Promote generic prescribing, and introduce a ‘white list’ system for prescriptions, using savings to phase out prescription charges and plough back any surplus into health care.

To manage difficult resource allocation decisions in a fair and efficient way, we would:

- Establish National Health Service Care Guarantees covering every major medical condition, which would set down the minimum standards of care that patients should expect. These would be drawn up the Secretary of State for Health, but with an obligation to consult with patients groups, health professional bodies, and expert external verifiers. Elected Regional Governments would also help draw up regional variations on the NHSCGs to take account of regional conditions.

We believe in the principle of an NHS free at he point of use. To reinforce this principle, we would:

- Abolish remaining eye and dental check charges.

Liberal Democrats would meet the challenge of caring for elderly people by:

- Supporting an end to charging for 'personal' care, as defined by the recent Royal Commission report, and giving this a high priority for resources.

- Introducing a three month 'breathing space' between entering care and making means-tested charges for living costs, in order to avoid people being forced to sell homes and become locked into residential care.

- Establish a National Care Commission to monitor care for older people, perform an advocacy role for the consumer, and encourage innovation and service improvement.

We believe that delivery of health and social care should be integrated so that the needs of individuals are met holistically. We also believe that the health service needs to become more accountable to the people it exists to serve. We therefore advocate:

- Allowing democratically elected Regional Governments to take over the NHS Executive Regions to provide democratic accountability for strategic planning of health and social care.

- Widening the composition of Primary Care Trusts and including local social services representation.

- Fully involving local authorities in the setting of Health Improvement Plans for their areas.

- Using pooled budgets in the context of Health Improvement Plans to promote integrated delivery of social and health care.

Introduction: The Present

1.1. Introduction

1.1.1 This paper addresses the issues of delivering and funding health and social care. The starting point for this exercise has been the need to consider how to deal with the perceived problems of long-term care and demographic change, the relationship between this issue and the long-standing ambition of merging health and social care, and how potential solutions can resolve the various anomalies in charging in the fields of health and social care.

1.1.2 However, in order to address this complex set of questions in a coherent and meaningful way, it has been necessary to consider the wider issue of priorities in funding care. This paper is therefore wide-ranging, and in some areas can only outline ways forward rather than give definitive answers.

1.2 Starting with People

1.2.1 This area of policy is one in which there is a large body of academic discussion, strong professional interests, and many difficult institutional problems. However, the fundamental starting point must be the needs of individual people. This requires us to see the whole person, and not categorise them as patients needing medical interventions, clients of social services departments, or even worse, 'the hip in bed 16'.

1.2.2 The overall objective of public policy should therefore be to help people to enjoy good health, to be able to work, live independently, and have a rewarding social life. This overall objective can be broken down into three components:

- Avoiding illness where possible.
- Treating illness or injury where they occur as effectively as possible on the basis of clinical need.
- Assist those with long-term illness or disability to lead the fullest possible lives, and to remain in their own homes as long they choose.
- Enabling people wherever possible to be able to contribute to society, whether through paid work, volunteering or caring.

1.2.3 It is clear that a wide range of policies, going beyond what might be traditionally thought of as health and social care - doctors, nurses, care homes - can play a part in realising these objectives. It also follows that public expenditure can most efficiently be used as a long term investment which reduces the need for expensive health and care programmes later in the life of the individual.

1.2.4 Above all, this approach recognises that the individual should have the maximum degree of influence over their own well being.

1.3 Current Problems in the NHS

1.3.1 The NHS has been seen for most of the post war period as a great British success story, and in many ways it has been. However, there are increasing grounds for concern that it is not up to the challenges ahead.

1.3.2 At the simplest level of analysis, Britain devotes less funds to health care than many comparable countries. In 1997 Britain devoted 5.7% of its Gross Domestic Product to public sector healthcare, while France gave 7.7% and Germany 8.1% (the EU average was 6.1%).

Including voluntary and private sector healthcare, Britain's position is even further behind - 6.7% of GDP compared with 7.9% for the whole EU. In terms of health care assets, this means that Britain has 2.0 acute care beds available for every thousand of its population, compared with 4.5 and 6.7 for France and Germany respectively; and 1.6 physicians per thousand compared with 2.8 and 3.3 for France and Germany. This relatively inferior position has fed through into public consciousness - a 1998 MORI survey showed that 73% of the population believed that the NHS is underfunded, and 47% believed the NHS would not exist in another 50 years.

1.3.3 The shortage of funds means that rationing of healthcare is a reality in the NHS, despite denials by Government Ministers. For example, cancer patients are denied access to the clinically-proven drugs Taxol and Taxotere depending on which Health Authority covers the area where they live. Similarly, there are schizophrenia patients unable to obtain Clozapine and Multiple Sclerosis sufferers unable to obtain beta interferon.

1.3.4 Rationing in the NHS is the limiting of access to NHS care due to demand (or need) for such healthcare exceeding its availability. In any system of publicly-provided healthcare with a limited budget rationing of healthcare is **inevitable** as need will always exceed the provision of effective services. That leaves two key policy issues:

- **The extent of rationing:** How much rationing there is (are we just rationing cosmetic surgery, baldness treatments and unproven popular treatments, or are we rationing cancer treatments, dialysis and prevention treatments as now) depends on the gulf between need and availability. The gap can be narrowed by demand management and/or health need reduction (i.e. prevention) on the one hand, or by additional and/or more efficient use of resources on the other.
- **Explicitness of, participation in and accountability for rationing decisions:** Where rationing takes place, accountability should lie with the politicians at that level (currently Westminster) where the decisions about resource allocation are made. Liberal Democrats believe there should be a public debate about rationing involving patients, carers, taxpayers, healthcare professionals, politicians and the media.

1.3.5 Despite the lower resources put into healthcare in Britain, some indicators of the overall health of the nation such as mortality rates show a roughly comparable performance with other European countries. This may reflect the fact that a much higher proportion of British health spending is in the public sector. Nevertheless there is hard evidence in the form of survival rates for a range of conditions including kidney failure, heart disease and breast, prostate, lung and colon cancer that the NHS is delivering worse healthcare than that in many Western European countries.

1.4 Long Term Care

1.4.1 The inadequacy of provision for long-term care of elderly people is also the subject of acute scrutiny throughout the Western World, as a consequence of increasing life expectancy. In the UK, life expectancy at birth increased during the course of the twentieth century from 49 for men and 45 for women, to 75 for men and 80 for women. This development has been associated with a considerable growth in local authority personal social services budgets - from £4.9 billion in 1986 to £9.3 billion in 1996 (although this increase is partly accounted for by transfer of responsibilities under the Community Care Act). There is strong demand for staff to deliver long term care - we are probably 7,000 nurses short of what is required to deliver existing Government commitments on care.

1.4.2 The means-testing of social services care has led to great financial anxiety for older people, as they see modest assets built up over a lifetime wholly or largely eaten up by care costs, leaving them without financial independ-

ence. This produces incentives not to save for old age. It has also created anomalies and perceived injustices; people do not understand why those treated in community hospitals get care free while those in local authority care have to pay (subject to means-testing), when the nature of the care received can be similar. The need to sell houses to pay for care can also lead to older people who might in the medium term have been able to resume an independent lifestyle being trapped in residential care, as they have no home to return to; and this very important decision can be rushed into at a time when people are vulnerable and not well prepared to make it. There is now a welcome move to develop effective rehabilitation programmes which enable people to receive the help they need to return to their homes and communities.

1.4.3 The recent British Royal Commission failed to come to a unanimous view, mostly due to the cost implications. The Government is due to respond in detail to the Royal Commission. In the meantime, policy is being established by court cases such the Coughlan case, where the North and East Devon Health Authority was prevented from closing the nursing home where Mrs Coughlan was being cared for. All policy-makers recognise this situation is not sustainable but there is little agreement so far.

1.5 The Liberal Democrat Response

1.5.1 In the rest of this paper we consider how current trends can be projected into the future, and suggest both short and long-term strategies to help deliver the quality of life which we have set out as the key objective of health and care policy. Underlying the whole is a fundamental conviction that an accountable and well funded national health and social care system is essential.

What Does The Future Look Like?

2.1 Introduction

2.1.1 Rapid developments in medical technology, demographics and social attitudes would render obsolete within a short timescale policy prescriptions based solely on current conditions. Before considering the right way forward, we therefore need to engage in the somewhat risky activity of trying to predict future trends.

2.2 Medical Advances

2.2.1 The range of medical treatments and technologies has expanded enormously in the last generation, and we must expect medical progress to continue. Even once we have identified likely technological improvements, however, it will not always be clear whether these will increase or reduce the resources which we will need to devote to health care.

2.2.2 Medical fields in which strides forward can be expected include:

- Genetics, especially pharmacogenomics
- Scanning and monitoring techniques
- Cardiovascular treatments
- Cancer treatments
- New 'lifestyle' improving drugs

2.2.3 Some of these developments may well create enhanced demand for medical treatments for conditions that were previously untreatable (e.g. triple therapy for HIV/AIDS, drug treatment of Alzheimer's disease). These therapies may in the long term bring savings in health and other budgets, though at least initially they may not outweigh the cost of treatment. Some new treatments may provide a more effective and acceptable treatment for non-

life threatening illnesses or conditions which will stimulate new demand, thereby causing a rise in treatment costs even if the treatment is relatively cheap. Viagra is a classic example of this - a new drug which has developed to meet a condition which many sufferers previously regarded as an inevitable and difficult to treat part of the ageing process. A senior Executive of Pfizer (the manufacturers) recently wrote in the Journal of the Royal Society of Arts: "The Viagra phenomenon is a sign of a larger trend in the pharmaceutical industry. It signals a new era in using medication to enhance and prolong people's lives - entering areas of healthcare that once seemed outside medical parameters". A related development is that drugs may be produced which will help counter-act the effects of poor lifestyles, and human nature being what it is many may demand these drugs rather than make the necessary lifestyle changes.

2.2.4 Other technological developments offer the possibility of both improving health and saving public resources. Improved transplantation techniques and drugs will create significant savings in replacement therapy in kidney disease, cystic fibrosis and heart failure. Some new therapies, indeed some which currently exist and are under-provided, are beneficial to health even when there is no significant extra demand generated. A good example of this is the under provision of life-saving cholesterol lowering drugs. The wider use of these have significant long term savings and health benefits, but which - because they are preventive and act on a hidden factor in the blood - are not in demand in this country. Advances in genetics are particularly exciting in this respect. Completion of the

Human Genome Project and the genetic analysis of individuals will enable us to identify the disease risks of particular individuals (although this also carries with it legitimate civil liberties concerns - see Policy Paper 31 *Keeping the Balance*). Appropriate lifestyle changes, monitoring and early drug interventions may then be adopted, which will delay or prevent the onset of conditions. It should even be possible to determine in advance which particular drugs individual patients will best respond to. It is open to question whether this will reduce overall medical costs, but it should certainly have a net positive effect on the national accounts as a whole, as people require less long-term care, or are able to continue in work when they might not otherwise.

2.2.5 We conclude that while the likelihood remains that demand for resources to fund new treatments will continue to grow, it should not therefore be assumed that new technology will always mean extra costs, and there is no need to fear a 'technological time-bomb'.

2.3 Social Attitudes

2.3.1 In many fields, the increasing individualism of society means that producer-consumer relationships are moving from what Professor Rudolph Klein has called a Church model to a Garage model. In health terms a Church model is a paternalist system driven by doctors, a Garage model is where the consumer takes his or her body in for repair and retains control over what happens to it.

2.3.2 The increased assertiveness of patients has been perceived as a problem by many practitioners. For example, there is resentment at the large number of GP appointments that are made for apparently trivial reasons, placing an extra burden on the NHS. There are also concerns at the large number of people turning to alternative therapies, sometimes of unproven effectiveness.

2.3.3 However, this development can also be channelled into highly beneficial courses. It has already been noted that individuals have a great deal of influence over their own health. An increased willingness to take responsibility for lifestyle decisions should be encouraged by a programme of public health education. This should start in school, but new technology such as telephone helplines, digital television and the internet offers many opportunities to make health information available to people of all ages. A better informed population which takes preventive heath action seriously and is capable of appropriate self-care will free up health resources to use in the new high-tech areas which address health needs individuals cannot influence themselves.

2.4 Demography

2.4.1 One of the key areas of debate on what the future holds is long term care of older people. Some of the bald statistics on the ageing of the population have led to fears of a demographic time-bomb. From 1997 to 2040, for example, it is projected that the number of people aged over 65 will increase at ten times the general rate of population growth. In 2031 it is anticipated there will be 36,000 people aged 100 or more. There are now 480, 000 people in long-term care, and 40,000 people a year are having to sell their homes to pay for care.

2.4.2 One of the clear conclusions of the Royal Commission was that fears of a 'time bomb' are exaggerated. The key consideration is not how long people live, but what their health is. Although data on health expectancy are not wholly reliable, it seems likely that elderly people will not on average spend any longer in care, despite increasing life expectancy; the period of infirmity which most people experience towards the end of their lives will just be further and further postponed. The evidence from the USA suggests that there is a real likelihood of some 'compression of morbidity' - that is, a shortening of the period of ill-health at the end of life. The figures are also less intimidating when seen in terms of the proportion of GDP which needs to be spent on care, rather than numbers of people. The Royal Commission projected that the present share of

GDP spent on care, 1.6%, would still be at the same level in 2021 and rise to 1.9% by 2051.

2.4.3 However, another possible development noted by the Royal Commission was that changes in family structure may reduce the number of informal family carers available in the future. Increasing levels of divorce and smaller numbers of children mean there will be fewer partners or children able or willing to look after elderly people who might with some support remain at home. The need for professional care in the home is therefore likely to increase, unless informal caring by the wider community can be encouraged.

What Should The State Pay For And How?

3.1 Investing in the NHS

3.1.1 Liberal Democrats are committed to raising the real terms resources available for the NHS and social care (see sections 3.4 and 3.5). As extra real terms funding becomes available from the sources identified in sections 3.3 and 3.4, decisions will need to be made on priorities for spending it. A Liberal Democrat Government would need to undertake detailed consultation with all stakeholders in the NHS to agree these new priorities in detail, but we set out below the main areas which deserve consideration.

3.1.2 Adequate development of the NHS has been hampered by frequent policy and priority changes. This delays implementation of medical advances and denies their benefits to British patients. For this reason we believe that health policy should be evolutionary and build on potentially beneficial changes bought at enormous cost over the last decades.

3.1.3 To this end we support the planned improvements in the four key areas of health care nominated by the Government, namely cancer, mental health, accidents and cardiovascular health. The Government has set targets, but these should already have been achieved by any competently managed modern health care system. We will monitor the performance of the Health Service in these key areas as the minimum acceptable progress in the NHS. We also identify health promotion, dental services and long-term care as further key priority areas where services should be developed.

3.1.4 To achieve even the targets outlined by the government, significant investments will be required:

General Staffing Shortages: The NHS is clearly understaffed in doctors, nurses, and professions allied to medicine, with shortages being particularly acute in certain specialities such as mental health nursing. Training needs must also be addressed.

Cancer: The most glaring inadequacies of the NHS are in the field of cancer treatment. Professor Karol Sikora, who until recently was head of the World Health Organisation's cancer programme recently wrote in the British Medical Journal,

"If we were in same league as providing the best care in Europe we would save 25,000 lives per year. If we were only up there with the average we would save 10,000 lives." Currently, the government is concentrating on trying to ensure that everybody with suspected cancer sees a specialist within two weeks of their GP deciding they need to be seen urgently. The resources made available for this are inadequate and, in itself, the two week limit is very unlikely to improve cancer outcomes. Significant increases in staffing, equipment and expenditure on anti-cancer drugs such as taxol are required for any chance of providing a European standard of cancer treatment. Resources directed towards anti-smoking campaigns, improving air quality and housing will reduce the morbidity and expense of largely preventable respiratory conditions including lung cancer, plus other respiratory conditions such as asthma, chronic bronchitis and emphysema.

Cardiovascular Disease: More resources should be devoted to lipid-lowering drugs and control of blood pressure and diabetes. This would result in reduced incidence of heart attacks and angina, lower death rates, fewer lost working days and fewer hospital admissions.

Mental Health: This has been a neglected sector, with chronic underfunding in terms of staff, premises and drug budgets. Some of this underfunding results not only in a worse outcome for the patient but also incurs extra health and social security costs. For example, failure to provide the new antipsychotic drugs such as Clozapine results in longer and very expensive hospital stays for patients treated with less advanced drugs.

Preventive Actions: Poverty and disadvantage are the most important determinants of ill health, and determined policy measures going well beyond the scope of this paper is required to tackle them. There is a wide range of other initiatives, outside traditional health care, which could help prevent health problems emerging in the first place. Improving access to family planning and sex education would reduce both the number of unwanted pregnancies and the incidence of sexual health problems. Road safety programmes and improvements to public transport would reduce the death toll on the roads. Expanding the range of health and fitness advice available to individuals, for example by use of the internet, would encourage positive lifestyle changes. Some specific groups in society (e.g. ethnic minorities) suffer measurably poorer health than the general population, and resources should be made available for public health actions tailored for these groups.

Restoring Dental Services: It is difficult if not impossible to access NHS dental treatment in many parts of the country. The first priority for extra resources in this field should be to widen access to those most in need.

Long Term Care: Delivering the recommendations of the majority report of the Royal Commission on Long Term Care should be an early call on new resources (see next chapter for more detail).

3.1.5 To make significant progress in these areas, it will be necessary and desirable over time to raise the proportion of GDP spent on the NHS to at least the West European average.

3.1.6 With the astounding speed of medical advances, it is imperative that we make policy for the future as well as correcting the inadequacies of the present. Technological developments in genetics and screening and the development of new drugs aimed at preventing disease will have a major impact on health care in the next 20 years. We are witnessing the early stages of a major shift away from treating conditions that have already arisen and towards predicting a person's risk and taking preventative action.

3.1.7 Clinical studies are currently under way to evaluate the benefits of screening in many different diseases such as osteoporosis and bowel cancer. We would support mass population screening should well-conducted clinical trials show this to be effective. We realise that, although cost savings will be made by reducing the need for expensive medical and surgical treatment, there is likely to be a substantial net cost from mass screening programmes. In the longer term, our knowledge of genetic and environmental predisposition to disease will develop to the point where we can target our screening and preventive programmes at those at highest risk of disease. Thus although the initial impact of screening will be to increase costs, there will be a significant improvement in cost-effectiveness as our understanding expands. Genetic screening will of course have to take place on a voluntary basis with appropriate counselling arrangements, and legislation to prevent improper use of test results.

3.2 The Case For a Comprehensive NHS

3.2.1 The previous chapters have described both the current serious underfunding of the NHS, and the likely future pressures which will tend to exacerbate this problem. Although we believe that significant extra resources can and should be made available, it is clear that in the short term the level of funding which exists in the leading developed nations is unlikely to be achieved. Rationing is therefore more acute.

3.2.2 One response to this situation would be to restrict the scope of NHS treatment to a defined set of 'core' services, and leave anything else to private provision. Core services would include treatments for all conditions which threaten life, cause pain or undermine the individual's ability to work or carry out necessary daily tasks. This approach would have the benefit of honesty compared to the existing double-talk on the issue, and would at least let individuals know where they stood and allow them to plan additional provision accordingly.

3.2.3 However, we oppose this approach for a number of reasons. Firstly, experience overseas, for example in New Zealand and Oregon, shows that it is extremely difficult in practice to determine what core services should be in an acceptable and useful manner. The number of treatments which can with a wide degree of consensus be categorised as non-core is very small, and restricting their availability on the NHS would save relatively little money (e.g. tattoo removal). Most of the likely candidates for non-core status are in fact highly controversial, and might well in some individual cases come within the broad definition of a core service. For example, infertility does not cause physical suffering, but for some infertile couples the mental anguish could be such as to impair their ability to carry on with normal everyday life. Similar points could be made with regard to other problems, e.g. impotence, morbid obesity, gender reassignment. Making general decisions on what is a 'core' service, without regard to individual circumstances, will lead to clinically unjustified, indirect discrimination which has no place in the NHS (such as the under provision of services for elderly and dying people where the 'loss of ability to work or to be useful to society' test will discriminate).

3.2.4 Secondly, such an approach is plainly inequitable and contrary to the principle of social justice. Far from producing 'equality of sacrifice', rationing will deny treatments to those unable to afford them, while the better off will still be able to pay for them. It will therefore inevitably contribute to a more unequal and divided society.

3.2.5 Thirdly, asking people to pay for 'non-core' services breaks the contract with taxpayers, who will feel they are paying twice for healthcare - once in their taxes, and again in charges. This is likely to diminish voters' commitment to the NHS in the long run.

3.2.6 Liberal Democrats therefore uphold the principle that the NHS should aim to be a comprehensive service, offering the most effective and cost-effective treatment affordable to all based on clinical need. Over time we aim to raise the level of funding in the NHS so that the mismatch between needs and resources which creates these dilemmas is substantially reduced. In any event some mechanism for rationing is required.

3.3 National Health Service Care Guarantees

3.3.1 Liberal Democrats do not want rationing in the NHS but it is a current fact of everyday life. In the absence of sufficient new resources in the short term Liberal Democrats believe there must be a full and open debate about rationing.

3.3.2 Any discussion of rationing has to grapple with the tension between on the one hand the problems of a system based on *local* discretion, which will inevitably create some degree of 'postcode rationing'; and on the other hand the problems associated with a system of more rigid *national* guidelines. Post code rationing - treatments being available on the NHS in one geographical area but not in another - is one of the most controversial and unpopular aspects of the funding crisis in health. However, in an under-funded system where the level of underfunding will vary geographically, no matter how sophisticated a system of resource allocation exists to balance the underprovision, postcode rationing will inevitably occur and will manifest itself in variable ways. For example, one health authority will under-commission the provision of new cancer drugs (such as taxanes) but will commission a larger amount of modern anti-psychotic drugs, while another authority does

the opposite. A system of national guidelines will tend to even out provision geographically (regardless of local needs) but the overall level of rationing will be constant. National guidelines can also provide enforceable minimum standards. The dangers of national guidelines are twofold. They will either require better provision than the average and result in treatment areas where there are no guidelines having their budgets raided; or they will require less provision than the average and the better-providing authorities will sink to the minimum standard. National guidelines reduce the freedom of local decision making based on local need.

3.3.3 We propose a system of National Health Service Care Guarantees (NHSCGs), with regional variants, as the cornerstone of an open and rational approach to NHS resource allocation. NHSCGs would cover every major medical condition, and would set down the minimum standards of care that patients should expect. The NHSCGs would be drawn up the Secretary of State for Health, but with an obligation to consult with patients groups, health professional bodies, and expert external verifiers. The Secretary of State and elected Regional Governments (see chapter 5) would also have to draw up regional variations on the NHSCGs to take account of regional conditions. NICE (the National Institute for Clinical Excellence) would have a key role in providing research on the most clinically effective and cost effective treatments within the scope of each NHSGC. At present, NICE is only examining new treatments as they become available. We believe that NICE resources (currently £9.8 million per year) should be significantly increased to allow it to evaluate existing treatments as quickly as possible. Better resourcing would also allow it to accelerate its work on new treatments, the current slow pace of which is hindering the development of new drugs.

3.3.4 The NHSGCs offer a sensible balance between excessive 'postcode rationing' and an over-rigid centralised approach. They will also ensure that political responsibility for rationing will squarely rest with those most responsible for resources - Government Ministers. To enhance Ministerial accountability further, we would create a statutory obligation on the Secretary of State to publish each year a list of all medically effective treatments not available on the NHS for reasons of affordability.

3.4 Raising Revenue

3.4.1 The size of the NHS budget is only one of many factors affecting our ability to meet the health and social care objectives we set out in the first chapter. Management and organisational decisions will have an impact, as will policies in other fields from education to housing. However, given the serious degree of NHS underfunding, increased resources must form part of any long term health and care strategy. There is no short-term 'magic bullet' solution to fund the NHS sufficiently. The answer to the chronic NHS underfunding is threefold – efficient management of the general economy, a refocusing of the Government's public sector spending plans, and economies where possible.

3.4.2 Labour has accumulated a large budget surplus, from which the Labour Chancellor refuses to make a clear commitment to raise NHS expenditure over the long term. The 1998 Comprehensive Spending Review promised a misleading £21 billion for the NHS of which very little has so far arrived. In the meantime, services have continued to decline despite the best efforts of NHS staff. Better resourcing is possible if the economy is sensibly managed to avoid the periodic deep recessions which have thrown long-term public expenditure planning into chaos in the past, and the fruits of economic success are directed towards key public services rather than tax cuts. The Government's present plans under the Comprehensive Spending Review envisage a 3.7% rate of real increase in the health budget over the lifetime of the current Parliament, compared with 3.1% over the eighteen years of Conservative rule. Such an increase is too modest, and it should be possible to improve on it even without additional revenue raising measures.

3.4.3 The Prime Minister's panic announcement this January of an intention, later watered down to an aspiration, to raise the share of GDP spent on the NHS to average EU levels within five years shows that the Governments' performance to date has been inadequate. Liberal Democrats would make this aspiration a firm commitment. One way to make a positive start, and to bring in improvements ahead of existing Government plans, would be to prioritise NHS spending over tax cuts in the forthcoming budget.

3.4.4 However, to guarantee that the objective can be reached, Liberal Democrats would be prepared to raise progressive taxation if it should be necessary to achieve it, with a commitment to use the extra revenues generated to boost NHS spending.

3.5 Making the Best of NHS Resources

3.5.1 In addition to raising the level of funding for the NHS, it is also essential to make savings within existing allocations where appropriate.

3.5.2 One role that NICE (the National Institute for Clinical Excellence) should perform is to assess all the treatments currently offered by the NHS for best practice and most up to date techniques. For example, extracting tonsils is of dubious medical value yet there are 80,000 tonsillectomies performed each year. In the long term, very significant savings could be made if the NHS limited itself to carrying out NICE - approved clinically effective treatments.

3.5.3 The current Government has focused the efforts of NICE on new drugs and treatments where there is very little data about the relative cost effectiveness in widespread clinical practice. This will result in new drugs and treatments being banned for NHS patients in this country, even though they have been deemed clinically effective by licensing bodies, before there is adequate data about their cost effectiveness in NHS clinical practice. The dangers of this are that innovation will be stifled, that the UK will miss out on new treatments as they are licensed and marketed elsewhere first, that there will be disinvestment in clinical trials and drug discovery in the UK, and that patients and our economy will suffer.

3.5.4 Liberal Democrats would refocus the efforts of NICE on existing treatments. We believe that NICE resources should be increased to allow this to happen (see 3.3.4). This would be a classic example of spending a comparatively small amount of money in the short term to reap major savings in the long term. Cost-effectiveness analysis must include savings made in public expenditure beyond the NHS drugs bill to reduce false economies.

3.5.5 NICE currently evaluates treatments not only on the basis of effectiveness and value for money, but also for affordability. We believe the last factor is for politicians to decide, not medical experts, and should be removed from NICE's remit (see 3.3.4 and 3.3.5).

3.5.6 The drugs bill of £4.3 billion is the biggest single item of expenditure in the NHS after wages. Substantial savings could be made by encouraging doctors to prescribe more cost effectively, specifically by prescribing generic medicines unless there is genuinely no alternative. In addition to setting a generic prescribing target of at least 80% (the current level is 68%), we would introduce a policy of automatic generic substitution. Community pharmacists would be allowed to substitute a generic product in place of a branded drug prescribed by a GP, and would be encouraged to do so as a matter of course, unless a GP specified in writing that substitution should not take place. The Government has estimated that savings of the order of £60-70 million per year should be achievable through generic substitution, although the British Generic Manufacturers Association claims that a figure of £1.2 billion is possible. We also advocate moving towards a system similar to that in Australia and New Zealand, whereby GPs may only prescribe drugs that are included on a 'white list'. This list would exclude drugs of dubious effective-

ness, or duplicate drugs where cheaper equivalents were available - based on the work of NICE. Such a reform should save a significant percentage of the current drugs bill. We would use the money saved from both these sources progressively to reduce prescription charges, and would phase them out completely once savings had reached the necessary level. Further savings beyond this point would then be ploughed back into the NHS (see 3.6.5).

3.5.7 The NHS suffers considerable losses every year through litigation over medical negligence claims. It obviously makes sense to reduce these costs as far as possible consistent with the rights of patients to have legitimate redress. This can be done in two ways - by reducing the number of cases giving rise to litigation, and by reducing the costs involved when cases do arise.

3.5.8 Litigation costs are concentrated very heavily in certain specialisms, e.g., obstetrics which accounts for £260 million, 80% of the total. Strong efforts therefore need to be made to identify the key weaknesses which underlie these problems. The Department of Health should undertake an urgent review, in consultation with the relevant professional bodies and Health Service Managers, to devise a strategy for addressing the problem.

3.5.9 In April 1999 new Civil Procedures Rules governing civil cases came into force. These new rules arise from the Woolf Access to Justice inquiry, and are aimed at speeding up cases reducing costs. In particular, they seek to encourage the use of Alternative Dispute Resolution (ADR) mechanisms. These reforms will need to be evaluated in due course to assess their effectiveness. If their results should prove disappointing, we may need to consider further measures to promote ADR as the first resort.

3.5.10 There is considerable scope for making savings through more efficient management techniques within the NHS. Administering payroll and accounting functions on the regional level is one example.

3.6 Charges

3.6.1 One option for raising extra money for the NHS would be the extension of charging. Charges are already made within the NHS for prescriptions, for eye and dental checks and for dental treatment. Charging for visits to the GP and for the 'hotel costs' of hospital stays are options which have been suggested.

3.6.2 Liberal Democrats are wary of this approach on the grounds that charges are a deterrent to seeking timely medical care. Experience with eye and dental checks showed that the number of checks dropped significantly after their introduction. This argument applies particularly strongly to GP visits.

3.6.3 In the case of hotel charges, a distinction should be made between living costs for those in long-term residential care (see next chapter) and those in short-term hospital stays; the latter will still have the costs of maintaining their normal home during their period in hospital, and it would therefore be unreasonable to expect them to pay double. Pensioners currently have their state pensions cut if they are more than six weeks in hospital; we believe this is ungenerous and inconsistent with the 'three month breathing space' recommended by the Royal Commission before charges for long-term residential care should be imposed.

3.6.4 We therefore advocate that:

- The remaining existing charges for eye and dental checks should be abolished
- GP visits should remain free
- There should be no hotel charges for hospital stays, and the existing period of six weeks in hospital before the state pension is reduced should be extended to three months

3.6.5 Prescription charges have since 1951 been the most glaring exception to the principle of an NHS free at the point of use. They have been accepted because there are large exemptions, for example for children and old age pensioners, and they raise the not insignificant sum

of around £350 million. However, they can still be an unwelcome financial burden on those requiring a large number of prescriptions who fall outside the limited definition of the chronically sick, and for those at income just above the level for exemption. As we have identified ways of making very substantial savings on the drugs bill (see 3.5.5 above), we therefore propose progressively reducing prescription charges, phasing them out altogether as and when these savings have reached the level required to replace the lost income.

Long Term Care

4.1 Introduction

4.1.1 The guiding principle of policy should be to make appropriate early interventions to support people in independent living. This will be both best for the individual and most cost-effective in the long term.

4.1.2 Liberal Democrats broadly accept the majority report of the Royal Commission into Long-term Care. In particular, Liberal Democrats accept the need, outlined in the Commission's remit, for a 'long-term, principled, and practical solution'.

4.1.3 A number of faults have been identified in the present arrangements for long term care:

- The system is complex and entitlement is unclear.
- Who pays for care is dependent on who and where the care is provided.
- Standards of care and its cost are too variable.
- Preventive work is squeezed out.
- Carers receive little support.
- The system encourages residential care.
- The system is service focused rather than client focused.
- The health/social care divide creates perverse cost incentives.

4.1.4 In reforming the system, Liberal Democrats wish to apply the following principles:

Self-reliance. The aim of our reforms must be a genuine transfer of power and resources to the citizen as patient, as user, as carer. To foster self-reliance or reduce dependency. It is based on recognition that most social care is provided not by statutory or even voluntary agencies, but rather by family members or other informal carers.

- Self-reliance does not mean isolation. For Liberal Democrats self-reliance must be set in the context of community. The strength of communities is their capacity to mobilise individual and collective responses to adversity.

- Independence and dignity. The central goal of policy on long-term care should be to ensure the greatest possible opportunity for older people to lead the lives they want to. Services should be directed to and for older people themselves.

- Intergenerational equity. The risk of needing long-term care should be spread across the whole population and over the lifetime of that population as the most efficient way of addressing both the risk and the cost of insuring against it.

- Co-payment. There is a shared responsibility between the individual and society to meet the costs of old age.

4.2 Personal Care and Living Costs

4.2.1 Liberal Democrats find the key recommendation of the Royal Commission that personal care should be free at the point of use highly persuasive, and its adoption should be a high priority for future expenditure. People in long-term care incur three kinds of cost. First, living costs (food, clothing, heating, etc.). Second, housing costs (rent, mortgage, council tax, etc.).Third, personal care costs that arise from frailty or disability. Living and housing costs are legitimate items that people should expect to meet themselves. Some of these costs may fall to be met through income maintenance but they are costs that fall on us all and reflect personal

choices and lifestyles. As such state support, over and above income maintenance should reflect an assessment of means. However, personal care costs fall heavily, unexpectedly and are beyond the control of the individual. For this reason personal care costs should be exempted from means-testing in all settings and instead be based on an assessment of need. The Royal Commission define personal care as the care needs that give rise to major additional costs of frailty or disability associated with old age. The Commission goes on to say:

"Personal care is care that directly involves touching a person's body (and therefore incorporates issues of intimacy, personal dignity and confidentiality), and is distinct both from treatment/therapy (a procedure deliberately intended to cure or ameliorate a pathological condition) and from indirect care such as home-help or the provision of meals."

4.2.2 The Commission make it very clear that an exemption from means-testing does not mean a demand-led system. A proper system of assessment of need will be essential. In addition cost control would be achieved by the National Care Commission (see 4.5) determining a maximum figure for personal care costs. Any costs exceeding this level would continue to fall on the individual and be subject to means-testing.

4.2.3 If the goal of greater independence is to be achieved a consistent approach to personal care costs is required. An examination of social service charges for care at home reveals that about a third of the income raised (£160 million in 1995/96) came from fees for intensive care delivered to people who have difficulty with at least one activity of daily living. Local authorities have adopted widely differing criteria to assess eligibility and ability to pay. The National Consumer Council points to "a chaotic picture of charging methods", "ambiguous" Government guidelines, and "confused" local procedures. This in itself represents an obstacle to integrated care and equitable treatment.

4.2.4 Personal care costs in the domiciliary setting should be exempt from charging. Such a restructuring of charges for domiciliary services requires a consistent national basis. First, it must not discourage poorer people from seeking help. Second, it should include an assessment of means. Third, it should charge for practical help such as cleaning and housework, laundry, shopping services, transport, and sitting services where the purpose is company. While maintaining charges for 'low-level' services it is essential that their value is acknowledged and that the system for setting and levying fees is fair, transparent and guarantees a consistency of approach across the country.

4.2.5 Critics of the Commission's proposals, including the two Commission dissenters, have stated that these changes will give rise to an increase in demand. But it should be understood that personal care would be provided not on the basis of demand but rather on an assessment of the level of disability and dependency. The main generators of increased costs in long-term care are likely to be around the standards of accommodation, food, and domestic help. Given the definition of personal care the costs are not likely to be driven up in the same way. Between 100,000 and 125,000 people in residential settings would benefit from excluding personal care costs from the means-test.

4.2.6 The straightforward living costs of staying in residential care should remain the responsibility of the individual, subject to means-testing. The level of the means-testing threshold of assets (currently £16,000) has been the subject of controversy under the existing funding regime, but if the Royal Commission proposals on personal care were adopted then raising the threshold would not be as high a priority.

4.3 Supporting Independence

4.3.1 Liberal Democrats place a strong emphasis on supporting independence. Policy and practice must be geared to achieving a change in attitude across society. Most older people do

not need any formalised long-term care, but many do receive informal care from a wide range of informal care networks within their family and beyond. In the current system assessment and commissioning of care are fragmented often leading to confusion and distress for the older person and their family, as a game of pass the parcel is played by the different agencies and disciplines. A reformed system must bring together all the relevant professions and skills around a single assessment and delivery gateway - Age Care Assessment Teams. The aim of such multi-disciplinary assessments should be to delay the onset of illness or dependency and increase autonomy and quality of life. The timing of the assessment is crucially important to the success of such a preventative approach.

4.3.2 Ahead of any further changes in organisational structures to realign the health/social care boundary there needs to be a clear timetable and targets for the implementation of the pooled budgeting and lead commissioning arrangements provided for in the Health Act 1999. Such arrangements will underpin the multi-agency approach proposed in this paper. The Age Care Assessment Teams would take charge of a pooled budget that included all the funds for aids and adaptations.

4.3.3 Information and advice services are an essential building block of a person centred approach to care provision. Information on health and rehabilitation, social and housing needs, social security entitlements, aids and adaptations, leisure needs, transport and education should be readily available with effective signposting to relevant agencies. Again as with assessment and commissioning there needs to be one point of contact. Such a service needs to be partnership based drawing together statutory, voluntary and private sector resources. A further reinforcement of the people centred approach would be to put advocacy services on a stronger footing. Older people should be entitled to call on the services of an independent intermediary to act for and on their behalf in dealings with those arranging care.

4.3.4 Liberal Democrats believe in helping people to stay at home where possible. There is much good practice in this country and overseas in enabling people to live at home for longer. Care and repair and handyman schemes that offer advice, support and carrying out work for older people should become the norm rather than exception. Quick intervention with appropriate aids or appliances can help to secure a person's independence and avoid a more costly intervention later. This should include the option of small loans to pay for aids and adaptations that would be secured through a charge on the person's home. Access to physiotherapy and appropriate forms of exercise also have a role to play.

4.3.5 In this context, another key recommendation of the Royal Commission which Liberal Democrats wish to support is to give people a chance to recuperate by granting a three month breathing space for people admitted into residential or nursing homes before they are subject to the means-test. The current system can lock people into inappropriate residential placements. When they have assets of £16,000 or more they are forced to take decisions about the disposal of their home to pay for their care at a time when they are ill-equipped to make such life changing decisions. The current discretionary power for local authorities to waive the means-test should be made mandatory for the first three months of a placement so that people have a chance to recuperate and regain their confidence and capability for independent living. Rehabilitation should be at the heart of a reformed care assessment process. Only after a further assessment confirms the care need should the means-test be applied. This change would help between 40,000 and 50,000 people per year.

4.4 Caring for Carers

4.4.1 Caring for carers is an important element in any strategy for long term care. Evidence to the Royal Commission showed that better outcomes, in terms of quality of care, are significantly affected by the contribution made by unpaid carers. For many carers the costs of

caring are considerable: financial, social and physical. Recognition is only the starting point. The Age Care Assessment Team should not decline to commission care or withdraw care in circumstances where a dependent older person does not live alone. This would enable a degree of flexibility that would help both older people and those who care for them. The new carers grant paid to local authorities by the Government as part of its National Carers Strategy is welcome. It provides a way of targeting resources to achieve investment in the way the carers are supported. However, the level of resources committed by the comprehensive spending review (£20 million in 1999/2000 rising to £70 million in 2001/2002) will only scratch the surface, and Liberal Democrats would seek to increase it significantly.

4.5 A National Care Commission

4.5.1 The changes proposed in this paper require a different approach to the setting and regulation of care standards. Liberal Democrats therefore support the proposed establishment of the National Care Commission (NCC) to provide a strategic view of the whole care system for older people. The NCC should have a monitoring role, an advocacy role on behalf of the consumer, provide guidance on national quality standards, and encourage innovation and service improvement.

4.5.2 An urgent task of the NCC would be to develop care quality ratings for different kinds of care setting. For example, do residents in care homes get bed sores, are they content, what are the levels of medication. Life, liveliness and frailty are not necessarily strangers. Such ratings would help to raise standards and inform people's choices about the kind of care they wish to receive.

4.5.3 The Government will shortly be publishing its proposals for national eligibility criteria and charging policies as part of its fair access to care review. They should be based on the principle that personal care is free at the point of use. The NCC would have responsibility for monitoring their implementation, reviewing their effectiveness and recommending modifications.

4.6 Conclusions

4.6.1 This Chapter has set out the Liberal Democrat response to the report of the Royal Commission. The main elements of the package towards which expenditure priorities should be directed are:

- Personal care free at the point of use in all care settings.
- A three month disregard on means-testing housing assets.
- A National Care Commission (NCC).

4.6.2 On the Commission's costing this package would cost £1.3 billion in a full year (1995 prices).

4.6.3 It would be possible to phase the introduction of free personal care by setting a lower maximum figure for personal care costs. This would allow policy-makers and practitioners the opportunity to measure the effectiveness of the change while containing costs. However, if it proves necessary to phase in the introduction of free personal care as a first step we would ensure that nursing care were made free in all care settings. This would end the current anomalous and indefensible arrangements.

4.6.3 We strongly endorse the view of the Royal Commission, both majority and minority, that reform will lead to greater efficiency in the use of public resources and thus offsetting savings. As the minority report says:

“The manifold inefficiencies of the existing system - ill-targeted benefits, unnecessary costs and perverse incentives - provide plenty of scope (for savings).”

Integration, Accountability, Efficiency

Note: The structures of the NHS are a devolved matter in Wales, and this chapter therefore applies to England only.

5.1 Integration of Health and Social Services

5.1.1 At present, there is no democratic input below the national level into the running of the National Health Service in England. Important decisions, from rationing to recruitment drives, remain the discretion of the Secretary of State for Health. The reforms contained within the 1999 Health Act do nothing to make the structures of the NHS more accountable. The inclusion of a token lay member on the Primary Care Group/Trust boards is inadequate. In order both to democratise the NHS and improve service delivery, it has been Liberal Democrat policy to bring Health Authorities under local authority control. The prospective benefits of this would be twofold:

- Those who commission health services would be democratically accountable to the local population they serve.

- Institutional integration with social services, and with other locally provided services, e.g. housing and leisure, would promote an integrated approach to service delivery focusing on the needs of the individual rather than administrative boundaries.

5.1.2 However, recent developments may call these arguments into question. The reforms of the 1999 Health Act substantially changed the commissioning structures of the NHS, in ways that Liberal Democrats view as broadly positive and would certainly not seek to reverse.

Commissioning powers are being devolved away from Health Authorities, down to new Primary Care Trusts serving populations of around 100,000. Although not democratically accountable, Primary Care Trusts will have to plan and act in terms of their population needs. Primary Care Groups are evolving at their own pace. Different styles are already emerging. Those PCGs which are dominated by former fundholding GPs are developing very differently from PCGs which are not. The future role of the Health Authorities remains unclear, but is likely to become increasingly supervisory and strategic. Despite ministerial denials, the general view is that once PCTs are functioning, Health Authorities will begin to merge. There may be a possible return to the days of the Regional Health Authorities. The argument for merging Health Authorities with Local Authorities as the key means of integrating health and social care and democratising the Health Service therefore appears to have been overtaken by events.

5.1.3 The Primary Care Trust structure still needs to be more locally accountable. There are, however, some problems with simply merging them with local authorities:

- Primary Care Trust boundaries are not coterminous with local authority boundaries, and may even straddle county borders. Very significant boundary re-organisation would be required in order to achieve coterminosity.

- Pressure on local politicians may lead to populism. Services deemed unpopular (for example mental health services) may suffer as a result of local pressure.

- A significant amount of specialist healthcare is commissioned in response to regional or

national demand. Local commissioning is not necessarily the best mechanism for delivering these services.

- It is not clear that institutional merger between health and social services agencies will lead to integrated service provision on the ground. Certainly lack of co-operation between existing local authority departments is not unknown. Conversely, a great deal has been achieved in delivering an integrated service without institutional merger, for example in Liberal Democrat controlled Somerset.

5.1.4 The regional tier is likely to take on an increasingly important role. The tendency towards large 'centre of excellence' hospitals with very wide 'catchment areas' emphasises the importance of regions in NHS terms. More generally, as the momentum for Regional Government in England strengthens, Regional Government will develop wide-ranging strategies cutting across policy areas to enhance the overall well-being and prosperity of their populations. They thus present a useful tier through which to pursue our stated objective of a people centred approach embracing joint working between agencies. For Liberal Democrats, this must take place in the context of fully democratic Regional Government, not the existing undemocratic Government Regional Offices

5.1.5 We therefore advocate a new approach to democratising the NHS. Liberal Democrats would:

- Allow democratically elected Regional Governments to take over the NHS Executive Regions to provide democratic accountability over strategic planning of health and social care, amending regional boundaries where necessary to achieve co-terminosity.

- Make Primary Care Trusts more responsive to local lay interests by widening their composition and including local social services representation.
- Fully involve Local Authorities in the setting of Health Improvement Plans for their areas.

5.1.6 The existing Health Authorities would have very limited residual functions in such a structure, largely in the fields of monitoring standards and public health. These functions could be discharged on a local basis by Public Health Officers reporting to the Regional Government.

5.1.7 Integrating provision of social and health at local level remains vital. The scope for confusion and duplication described in the previous chapter in the context of long-term care exists more generally. Local initiative is the key driver, but other important mechanisms for achieving integration are pooled budgets in the context of the Health Improvement Plan (HImP). Regional HImPs should be set by the merged Regional Government/Regional Health Authorities advocated in section 5.1.5, and then by PCTs at that level in concert with local authorities and others.

5.2 Efficiency

5.2.1 In addition to providing more funding for the NHS and social care. it is also necessary to ensure that structures are in place to manage resources effectively both in terms of quality and value for money.

5.2.2 Liberal Democrats support the principle of a purchaser-provider split within the NHS as key tool to raise standards and promote efficiency. The crucial underpinning of this approach is residence based funding. This gives commissioners of services, whether GPs, Health Authorities or Primary Care Trusts, the freedom and the incentives to seek the best possible provision for the population in their care. One of the main reasons why the Conservatives' Internal Market reforms achieved disappointing results was that commissioning was not allowed to be sufficiently dynamic. After quite a vigorous start, Health Authorities were discouraged from taking too much initiative in seeking the best services for their residents. The same excessive central control is still apparent under the present Government.

5.2.3 The creation of Primary Care Trusts, should provide an opportunity to energise commissioning, but it won't happen without a clear commitment to innovative purchasing from the centre and greater freedom for local decision making.

5.2.4 Liberal Democrats also take a relaxed attitude towards the NHS commissioning health care from private or voluntary sector suppliers, providing that care remains free at the point of delivery to patients, gives good value for money and that the quality of such care is monitored by the Commission for Health Improvement. For example, where the private and voluntary sector has excess capacity for elective surgery, it may make sense for the NHS to take advantage of this.

Appendix: Facts and Figures

1: Health Expenditure Comparisons (1997)

	Public Health As % of GDP	Public Health £ Per Person	Total Health As % of GDP	Total Health £ Per Person
UK	5.7	752	6.7	889
Germany	8.1	1,265	10.4	1,634
France	7.7	1,124	9.9	1,433
Portugal	4.9	296	8.2	493
EU Average	6.1	839	7.9	1,083

Source: OHE Compendium of Health Statistics 1999 (based on OECD Data)

2: Cancer Survival Rate Comparisons

	England & Wales	EU Average	USA
Breast Cancer	68%	73%	84%
Colon Cancer - Men	38%	47%	64%
Colon Cancer - Women	39%	47%	63%
Lung Cancer - Men	6%	10%	13%
Lung Cancer - Women	6%	11%	16%

Source: White Paper 'Saving Lives: Our Healthier Nation'

3: Death Rate from Circulatory Disease

	UK	France	Germany
Deaths per 100,000 population (under 65s)	70	36	64

Source: White Paper 'Saving Lives: Our Healthier Nation'

4: Typical Treatment Costs

Item	Cost (£)
Coronary by-pass graft	7,500
Renal dialysis for one year	22,420
Kidney transplant	18,580
One adult intensive care	1,200
Visit from health visitor	22
Visit from community nurse	15

These figures are inevitably approximate. Source: NHS Week

5: Scale of NHS Activity

The United Kingdom NHS budget for 1999/2000 is £48 billion, making it the second largest item of public expenditure after social security. In a typical week, the NHS will perform around 1,200 hip operations, 3,000 heart operations and 1,050 kidney operations. In the same time, around 800,000 people will be treated as outpatients, 8.5 million items will be dispensed on prescription, and over 10,000 babies will be delivered. *Source: NHS Week*

This paper has been approved for debate by the Federal Conference by the Federal Policy Committee under the terms of Article 5.4 of the Federal Constitution. Within the policy-making procedure of the Liberal Democrats, the Federal Party determines the policy of the Party in those areas which might reasonably be expected to fall within the remit of the federal institutions in the context of a federal United Kingdom. The Party in England, the Scottish Liberal Democrats and the Welsh Liberal Democrats determine the policy of the Party on all other issues, except that any or all of them may confer this power upon the Federal Party in any specified area or areas. If approved by Conference, this paper will form the policy of the Federal Party, except in appropriate areas where any national party policy would take precedence.

Many of the policy papers published by the Liberal Democrats imply modifications to existing government public expenditure priorities. We recognise that it may not be possible to achieve all these proposals in the lifetime of one Parliament. We intend to publish a costings programme, setting out our priorities across all policy areas, closer to the next general election.

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