

# **Building on the Best of the NHS**

## **Proposals to Reform the National Health Service**



### **Policy Paper 14**

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# Summary

Liberal Democrats believe in the National Health Service and the founding principle of a service available to all and free at the point of need. However, we do not believe that the NHS is, or ever has been, beyond reproach as an institution.

For this reason, the Liberal Democrats do not propose to go back to the past but to move forward by building on the best of the NHS.

This means creating a Health Service in which the involvement of, and accountability to, the public is at its heart. We will:

- Recognise the effect poverty, poor housing and pollution have on people's health and make health promotion a priority.
- Develop the role of commissioners of health care (such as health authorities) and, by making them properly accountable, give local people a real say in the services that are provided in their area.
- Ensure that health authorities are more open and accountable to local people and that they work more closely together with social services departments to achieve a seamless provision of care, so that no one falls through the net.
- Make NHS Trusts more representative of, and responsive to, local people. Their decision making processes would be opened up and "gagging" clauses that prevent staff from speaking out about poor patient care would be banned
- End the built-in two tier service the Conservatives have created by introducing a common basis for allocating funds to GPs, whether they choose to manage those funds themselves, decide to be part of locally based consortia or ask the local health authority to manage the funds on their behalf.
- Establish a National Inspectorate of Health and Social Care to oversee the workings of all parts of the Health Service in order to maintain and raise standards in the public and the private sectors and to promote the interests of patients.
- Continue to fund the NHS from general taxation and meet the increased costs resulting from demographic change and technological advance.
- Provide extra resources for health by earmarking the revenue from increased tobacco taxes and by reducing demand through a wide range of health promotion policies
- Abolish charges for eye and dental checks and freeze prescription charges.
- Establish a more deliberative and consultative means of priority setting in the NHS.

# *Introduction*

Three years ago, in Federal White Paper 5, *Restoring the Nation's Health*, Liberal Democrats spelt out a comprehensive policy for health care in Great Britain covering all aspects of the service provided by the NHS. At the time, the policies contained in the Government's White Paper *Working for Patients* were at an early stage of implementation: the internal market and hospital trusts were only just beginning.

All those who care about the Health Service have to recognise the dramatic changes in the way health services are organised and health care is provided since 1992. This does not mean that Liberal Democrats accept all these changes without criticism. At the same time we do not wish to return to the NHS of the past. We recognise the reality that any further upheaval in the NHS, even with the best of intentions, will further lower morale and impede the NHS's ability to care for patients.

In this paper we have chosen to concentrate on the Liberal Democrat approach to the structure and funding of the National Health Service, its priorities and the impact it has on the health of the nation. Much of the detailed policy proposals of our earlier paper remain unchanged. We have decided to focus on these key issues and to do so by attempting to answer four basic questions.

- How should the Health Service be organised and who should control it?
- How do we ensure that the health care provided is both cost effective and of high quality?
- What are the options for increasing the funding of the Health Service?
- What mechanisms should exist for determining priorities within the Health Service?

In developing our policies, Liberal Democrats have been guided by the following principles.

- 1) Looking at broader health issues, not just within the narrow confines of the Health Service.
- 2) Ensuring equality of access to health services.
- 3) Providing quality services.
- 4) Decentralising service delivery and control.
- 5) Emphasising the importance of strategic planning, at local, regional and national level.
- 6) Ensuring effective accountability for the use of public money.
- 7) Involving local people in determining the priorities for their area.
- 8) Opening up decision making - which means being open about costs.

This paper should be read in conjunction with Policy Paper 1 *A Caring Society* (1992), our paper on social services and community care, and chapters 3 - 6 of *Restoring the Nation's Health*.

# A Healthy Society

**1.0.1 Liberal Democrat health policy puts people first. A person's health is central to their quality of life and their ability to fulfil their potential. Ill-health may restrict a person's independence and their ability to make the most of life's opportunities - in education, work and recreation - and to contribute fully to the well-being of society.**

1.0.2 Liberal Democrats recognise that high standards of health are not mainly determined by the quality of health care. Beveridge argued that the National Health Service should be only one part of “a comprehensive policy of social progress”. The 1991 Government white paper, *The Health of the Nation*, dealt with the promotion of better health. Whilst it contained many useful proposals, it fell far short of a proper survey of health needs by deliberately avoiding references to poverty, social inequalities and injustice, unemployment, bad housing, poor education, and environmental degradation. Liberal Democrats are committed to the establishment of a comprehensive strategy to address these major factors which contribute very significantly to ill-health.

1.0.3 This paper is primarily concerned with the National Health Service. But the Liberal Democrat commitment to raise standards of health goes far beyond the defence and reorganisation of the NHS. It incorporates proposals contained in a whole range of other policy papers to address social and economic inequalities, to improve housing, raise standards in education, to tackle pollution and get people back to work and to enable people to take responsibility for their own health. In particular, these proposals include:

- Education, to teach people more about how their bodies work, to prevent illness and help them to spot problems earlier (Policy Paper 10, *Equal Citizens*, 1995, and English Green Paper, *Excellence for All*, 1992).
- Action to reduce the degradation of our environment and promote its sustainability, including the implementation of EU directives on drinking water and beaches and policies to reduce energy consumption (Policy Paper 8, *Agenda for Sustainability*, 1994).
- Measures to reduce poverty, deprivation and social inequality, including reform of the tax and benefits systems and action to help people living in poverty to help themselves (Policy Paper 7, *Opportunity and Independence for All*, 1994).
- Measures to increase meaningful employment, including investment in Britain's infrastructure, in education and training (Policy Paper 9, *Working for Change*, 1994).
- Measures to tackle homelessness, including increased provision of social housing and reform of housing revenue support (English Green Paper 6, *A Place to Live*, 1992).
- The promotion of healthy living, for example, encouraging physical activity and better nutrition. This includes not just urging people to change their behaviour, but making healthier choices easier by, for example, providing fiscal incentives to insulate homes and building safe cycle lanes in towns and cities (Policy Paper 8, *Agenda for Sustainability*, 1994, and English Green Paper, *Planning for Sustainability*, 1993, and others).
- Action to reduce unhealthy lifestyles, for example, discouraging smoking and alcohol misuse in ways including a ban on the promotion of tobacco, except at point of sale, in line with a proposed EU directive which has been accepted by almost all the other EU countries. (The failure of the Government to introduce such a ban is perhaps the single greatest betrayal

of its own *Health of the Nation* strategy, and a clear reflection of its dependence upon the tobacco industry for funds.)

1.0.4 Without Liberal Democrat action to modify a whole range of economic, environmental and social factors, some of the

resources invested in health care will effectively be wasted. By promoting good health, as well as diagnosing and treating the problems of ill health and caring for those with chronic sickness, Liberal Democrats aim to release the potential of all Britain's people, for the common good.

# Putting Patients Before Dogma

**2.0.1 The greatest achievement of the National Health Service has been the extent to which it has been able to make good quality health care available to all, regardless of ability to pay. The Conservatives' uncontrolled internal market is in danger of destroying this achievement.**

2.0.2 The Liberal Democrats are wholly committed to the National Health Service. We believe wholeheartedly in its founding objective of making health care equally available to all on the basis of need rather than the ability to pay.

2.0.3 Liberal Democrats are determined to defend the National Health Service, from Tory attacks and from Labour mismanagement. The Labour Party also talks about defending the NHS, but would simply return the NHS to the old problems and inefficiencies.

2.0.4 To believe in the National Health Service is not to suggest that it is, or ever has been, perfect. For forty years, the NHS sought to provide a comprehensive quality service more efficiently and cost effectively than the comparable services in other countries. In many respects it succeeded, yet room for improvement remained. The NHS was underfunded, over-centralised and over-secretive. It was too often run in the interests of health providers rather than users. It paid too little attention to health promotion and other 'quality' issues received insufficient attention. Resources were poorly distributed and, as a result the availability of services varied significantly from area to area and community to community.

2.0.4 Liberal Democrats, in contrast, are committed to building on the best of the National Health Service, to providing quality services and value for money for all and to putting patients first.

## 2.1 The Liberal Democrat Approach

2.1.1 For Liberal Democrats there are three distinct, but interdependent aspects to the provision of health care:

- *Policy Making:* Determining the values that underpin health policy at local regional and national level. Setting the overall goals of health policy. Deciding the level of resourcing of health services. Liberal Democrats believe that such decisions should be acceptable to the majority of people, yet should not discriminate against minorities.
- *Commissioning:* Assessing the health needs of a given population and developing strategic plans to ensure that services are provided to meet those needs, within the resources available. This includes both the provision of facilities and ensuring that there are sufficient numbers of appropriately skilled and trained health care workers. This role is currently carried out by health authorities and GP Fundholders.
- *Providing:* Ensuring that health care meets the health needs of the local population, is available at the locations and at the times specified by the commissioners of health care and that this care is of the optimum quality. This role is currently carried out by NHS Trusts and the remaining Direct Managed Units.

2.1.2 Separating these three aspects provides a useful framework for determining the responsibilities of all those involved in the health service. However, this does not mean that the staff and institutions involved in each of these three aspects should be isolated from each other. It is plainly in the best interests of those using the health service if there is co-

operation between these different parts of the service. For example, staff who are directly dealing with patients may be in the best position to identify possible changes that could be made to improve the service, and they should be encouraged to propose such changes to the commissioners. Similarly, the commissioners might recognise the trends in the health status of the population for which they are responsible, and be able to suggest changes of policy to the political decision makers.

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## **Liberal Democrats are committed to building on the best of the NHS, to providing quality services and to putting patients first.**

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2.1.3 The Conservative Party have perverted such a sensible division of responsibility through a dogma-driven attempt to impose a simplistic and artificial market solution to the ills of the NHS. Conservative dogma on health has failed for the following reasons:

- *Attempts to manage the health market have resulted in beds being lost and hospitals closed before other community-based services have been put in place to replace them.* The Government has refused to accept that the move from acute to primary and community care is not a cheap option.
- *Maverick purchasers and providers, acting outside local health plans and nationally-agreed priorities, are creating a built-in two tier health service.*
- *Patients choice has not increased.* There is neither the surplus of suppliers nor customers with commissioning power to allow any but the luckiest, or richest patients with a real choice.
- *It has largely failed to drive down prices, except by lowering the quality of treatment or by abusing the goodwill of committed*

NHS staff in manner which cannot continue.

- *There has been greater secrecy, supposedly to safeguard commercially sensitive information.* As a result, in the very few areas where there is an excess of a few services, patients do not have any information on which to base their choices. The Government's crude hospital league tables are no substitute for full and objective information upon which proper decisions can be based.

2.1.4 Liberal Democrats reject the Conservative Government's commercialisation of the NHS. We do not believe that it is necessary to be able to recognise the distinct roles for those who provide and those who commission health care. We believe, as do many health care professionals, that separating these functions and developing the role of commissioners would be a positive step for the following reasons

- The 'transparency' of the processes of commissioning and providing is substantially increased allowing actual costs to be allocated to services.
- Commissioners can force hospitals to provide services that are more likely to be needed by the community, rather than the ones which consultants want to provide.
- Commissioners can be more flexible, cost-effective and innovative in the services which they commission.
- Where changed clinical practices have resulted in surplus capacity it would be possible to redirect resources into areas where they are really needed.

2.1.5 A further reason for developing the distinct roles of commissioner and provider is that there would be no need to have another major reorganisation of the NHS. This is the last thing the NHS needs. Those who propose the reversal of all the recent NHS reforms are living in the past. They are doing the NHS no favours: those who work in the service to serve the public would throw up their arms in despair at the thought of yet another major



reorganisation. Those who really want to defend the NHS, who respect the views of doctors and nurses, recognise that the NHS needs evolutionary change not constant dogma driven upheaval.

2.1.6 Liberal Democrats will reform, rethink and redirect the Conservative Government's changes in a positive way. We will:

- Preserve the founding principle of public service
- Reform those parts of the Government's changes that have created a built-in two tier service.
- Make all parts of the Health Service accountable for the money they spend.
- Ensure that the services provided reflect the wishes and needs of local communities
- Give the public, patients and staff an effective voice within the NHS

## **2.2 A Health Service Answerable to Local People**

2.2.1 The present structure of the National Health Service is both over centralised and unrepresentative of the people it is meant to serve. For too long the running of the Health Service has been dominated by professionals, both medical and administrative. The Conservative Government has exacerbated these problems by ending any semblance of local representation on District Health Authorities, abolishing Regional Health Authorities and merging District Health Authorities into larger units. Those running the NHS have, therefore, become further removed from local people and less representative of them.

2.2.2 The Government's changes to the structure of the Health Service at a local level, with the merger of Health Authorities with Family Health Service Authorities continues. This, combined with the work of the Local Government Commission, has led to variations

in structure across the country and unclear relationships with the structure of local government. Some health authority boundaries are no longer coterminous with those of local authorities and the local government review means that, in some cases, responsibility for social services is shifting from county to unitary authorities.

2.2.3 Liberal Democrats have long been committed to closer working relationships between local health authorities and social service departments with a view to their eventual merger. Following the Government's changes noted in 2.2.2 we believe that such a merger will best take place in the context of a review of the structure and functions of local government, including the workload of councillors. We also believe that such a review should be part of the process of developing regional assemblies in England.

2.2.4 Liberal Democrats believe that there should be a regional tier within the health service and we oppose the Government's abolition of Regional Health Authorities and the centralisation and secrecy that is the result. As proposed in *A Caring Society*, we would establish Regional Health and Social Services Authorities made up of representatives from the authorities responsible for social services and health within the region.

The authorities would:

- Ensure equal access to services within the region.
- Plan specialist services.
- Oversee local health authorities and Trusts.
- Appoint the members of local health authorities and Trust boards in their region.

These responsibilities would be transferred to regional government once it is established.

2.2.5 Liberal Democrats also believe that action must be taken now to address the democratic deficit in the health service at a local level. We believe that those responsible for commissioning services for local people must be accountable to local people. This

means tackling the unrepresentative and unaccountable nature of local health authorities. Liberal Democrats will:

- Make it mandatory for at least 50% of the membership of the Health Authority to be drawn from the local population and for this number to include local councillors.
- Open up the process of making appointments to health authorities, including a requirement to advertise all vacancies.
- Give local people, their councillors and the staff of the Health Authority the right to "contest" any appointment and the regional assembly (when established) to scrutinise appointments.
- Ensure that staff are adequately represented on health authorities.
- Require health authorities to maintain close relationships with their local Community Health Council and ensure that the CHCs are properly consulted and have increased access to information.
- Ensure that meetings of health authorities are open to the public and the press and that local people, staff and professionals have speaking rights.

Local health authorities will continue to carry out their existing responsibilities. In addition, they will be required to undertake effective strategic planning of local health services based on thorough needs assessment.

## **2.3 Towards a Comprehensive Care Service**

2.3.1 Most health care currently takes place in the 'primary' sector, that is care delivered by GPs and other community health services. Despite the frequent link between health care needs and social services needs and the requirements of 'Care in the Community', all too often health and social service professionals fail to make those links. Much energy and time wasted by doctors, nurses and

social workers arguing whether a particular care package is the responsibility of the health service or social services.

2.3.2 For these reasons Liberal Democrats have long argued for health authorities and social services departments to work more closely together. A much closer relationship between these two bodies would have a number of distinct advantages:

- Joint commissioning between social services departments and health authorities would be easier.
- Prevent one authority from trying to off-load the costs of meeting care needs onto another.
- Health commissioners would be more receptive to the needs of local people.

2.3.3 We are therefore committed to the integration of health and social care services through a considered step-by-step approach:

- First, we would complete the merger of district health authorities (DHAs) with family health service authorities (FHSAs) within two years.
- Second, and concurrently, we will continue the separation of the commissioner and provider roles of local authorities with respect to social services, retaining commissioning within local authorities. However, there is a case for local authorities retaining the power to act as providers, particularly where others are unable or unwilling to provide services locally.
- Third, we would develop joint commissioning models for local authorities and the newly merged DHAs and FHSAs, with local authorities having automatic nomination rights for two of the five non-executive members of new joint commissioning agencies.

We would also extend the role of Community Health Councils to include community care and entitle patients to the support of advocates if

they require help in arguing for the type and place of care they want.

## 2.4 A Comprehensive Service, Not a Two Tier Service

2.4.1 GP Fundholding now covers a third of all GPs and 40% of patients. This element of the internal market does seem to have brought benefits, at least for GP fundholders and their patients (although arguably at the expense of the patients of non-fundholding GPs).

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### We propose a unified system of funding for all Gps.

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Ironically, the scheme's popularity is founded upon the fact that it has enabled GPs to evade some of the restrictions of the internal market. It helps them to keep control of their patients' hospital treatment, which would otherwise be lost under the contract system to health board managers. By holding a part of the hospital services budget, GPs are now able to demand a better deal for their patients, resulting in the turnaround times for laboratory and other tests being vastly improved and services becoming more personal. GP fundholding has, however, several disadvantages: it makes systematic planning by health boards more difficult; it means that care for the patients of fundholding and non-fundholding GPs is commissioned separately, resulting in a two tier service; and it gives GPs the power to alter substantially the nature of local services without reference to local people. These disadvantages are now widely recognised, even by the Conservative Government, which is also seeking to tackle the problems that have arisen.

2.4.2 *Liberal Democrats would extend the principles of GP fundholding, whilst addressing the system's weaknesses.* This means:

- *Generalising and extending the mechanism of fundholding to all GPs.*

- *Making the mechanism of practice-based fundholding dependent upon evidence that GPs can manage a fundholding practice properly* - obtained by audit and formal accreditation - rather than upon the size of their practice.
- *Retaining the financial interest of GPs in the cost of care, but ending their financial advantage over non-fundholders.*

2.4.3 There are two main reasons why the patients of GP fundholders generally seem to get a better deal than those of non-fundholding GPs. The first is that the financial flexibility of Fundholding GPs enables them to provide more innovative forms of care. The second is that fundholders are allocated their money on a different basis from other GPs, giving them a financial advantage, based not on need, but on their fundholding status. It is this second aspect of fundholding which is leading, unacceptably, to the development of a two tier service.

2.4.4 *We therefore propose a unified system of funding for all GPs.* All GPs would be allocated funds by their joint commissioning agencies on the same basis as the joint commissioning agency are allocated funds by the Department of Health, taking into account the age, social mix and medical needs of their practice population. Each GP would then be free to manage their budget as they wish:

- *Either* independently, subject to strict accreditation (see 2.4.2) and the expenditure of annual savings in accordance with plans agreed in advance with funding bodies.
- *Or* as part of a local consortium of GPs, enabling those with smaller lists to share in the benefits of fundholding, subject to the same conditions as above.
- *Or*, if the other options are unacceptable, by asking their local health board to manage the budget directly as the GP's agent.

2.4.5 To facilitate the planning of health services, every type of GP would be expected to contribute to the formulation of annual health plans through discussions with local provider units. GPs would be expected to work within these health plans and would be

consulted in their preparation. However, GPs would be free to refer patients outside the local authority area, however, so long as referrals accorded with nationally agreed priorities. This would ensure that GPs were able to develop individualised care packages for patients. Liberal Democrats believe that GPs should continue to act as advocates for their patients, ensuring that they receive the kind of care they want.

2.4.6 The concept of total fundholding - where GPs would be able to commission both health and social care on behalf of their patients - has recently gained currency. Liberal Democrats believe that total fundholding does warrant careful evaluation although it is a status that would need to be subject to approval of GP's competence. We will monitor the current pilot schemes for total fundholding with interest.

## 2.5 Changing the Status of NHS Trusts

2.5.1 The Government's changes have set out intentionally to erode democratic control of the health service. Power has been shifted away from democratically accountable bodies and towards unaccountable health service providers, such as NHS Trusts. Liberal Democrats would change the status of NHS Trusts making them accountable to local people for the service they provide.

2.5.2 NHS Trusts should be accountable through the contracting process to the commissioning bodies. However, Trusts should also be sensitive to local needs and traditions. To that end we would:

- *Increase the representation of local people on Trust boards.*
- *Require Trusts to publish their annual plans.* These will be open to "contest" by staff, patients and local people and their representatives.
- *Require Trusts and health authorities to make public their external auditors' reports,* so that it is clear whether or not they are providing good value for money.

- *Ban the use by Trusts of contracts of employment which contain 'gagging' clauses,* preventing professional staff from speaking out against unsafe standards.

2.5.3 Some NHS Trusts have attempted to represent adequately local people on their boards and at the very least all NHS Trusts should follow this example. However, much more needs to be done to make Trusts accountable and responsive to local people. We will:

- Make it mandatory for at least 50% of the membership of Trust Boards to be drawn from the population served by the Trust.
- Give Regional Health and Social Services Authorities the responsibility of making appointments to Trust Boards. The process for appointing Trust Board members would become more open, and would include a requirement to advertise all positions.
- All appointments would be scrutinised by the Regional Assembly (when established) and local people, their local councillors and the staff of the Trust would be able to "contest" any appointment.
- Guarantee direct representation from the staff of the Trust.
- Require all Trusts to maintain close relationships with their local Community Health Councils and their staff.
- Ensure that professional opinion was fully represented at the public meetings of the Trust Management Boards.
- Give Community Health Councils greater rights to consultation and access to information and meetings (see *A Caring Society*).

We do not believe that commissioning bodies should be represented directly on Trust Boards because of the significant conflict of interest this would involve.

2.5.5 Trusts could be created (for example by breaking away from an existing Trust) or continue to exist despite regional or national

plans to close them if they believe that they still have a viable future in that form. These decisions should be taken by each Trust or appropriate part of the Trust.

2.5.6 Consideration will be given to opening up the management of Trusts to competition. Management teams will be invited to present bids to the relevant regional health authority to run a Trust for a fixed period. Any such scheme will be properly piloted before full implementation.

2.5.7 Liberal Democrats recognise that with advances in medical technology, 'acute' hospital services are becoming more expensive

and less able to be efficiently provided in small district general hospitals.

2.5.8 Hospitals and centres delivering specialist services, such as renal transplants should be commissioned on a regional basis in consultation with GPs and local health boards. All GPs in the region could refer patients to these specialist units and, if necessary, health boards could 'buy in' extra services for their patients for example extra diabetes services in an area where the incidence of diabetes is particularly high. For such regional centres it may be appropriate for the Trust Board to be chosen in order to reflect the region as a whole, not just the local area of the Trust.

# Providing Cost Effective Quality Services

**3.0.1 Treating health simply as a market commodity has generally failed to reduce costs or to improve the quality of care. It has exacerbated inequalities, and any savings resulting from increased efficiency have often been more than offset by administrative and bureaucratic costs. Where costs are being forced down the savings are almost exclusively at the expense of standards of patient care.**

3.0.2 While Labour has little interest in managing the Health Service's scarce resources for the benefit of patients and the Conservatives' only concern is cost, Liberal Democrats, in contrast, believe in getting the best possible *value for money from the health service*. We understand that both costs and quality are important when commissioning health care.

3.0.3 Whilst Conservatives constantly talk about value for money their policies make it impossible to take quality into account. This is for three reasons:

- *The internal market is based primarily on price competition.* The quality of the service being offered plays second fiddle to its cost when determining contracts.
- *The secrecy - in the name of commercial confidentiality - surrounding providers' pricing policies* makes it extremely difficult for commissioners to determine what they are getting for their money. Such secrecy is completely unacceptable in a public service using public funds.
- *There is far too little information generally available about the likely outcome of different treatments* making it hard for commissioners to assess the quality of services even when they wish to do so.

## 3.1 Quality and Efficiency: Getting Value for Money in the Health Service

3.1.1 Liberal Democrats are determined to address the problems of secrecy, lack of information and price-based competition and to ensuring both *quality and efficiency*. We would:

- Develop meaningful indicators of quality service provision, backed up by regular monitoring and inspection of standards.
- Require providers to publish their pricing policies and specify quality standards.
- Establish indicative UK-wide prices (or price bands) for services.
- Encourage realistic contracting cycles for core services to address the problem of "short-termism".
- Stop NHS Trusts contractually 'gagging' their professional staff to prevent them from speaking out about unsafe practices.

3.1.2 Since any assessment of value for money is, to a certain extent, subjective, we believe that individual patients should be given a much greater say in what services they receive, and how, where and when they are delivered.

3.1.3 We believe that dogma has no part to play in ensuring quality and efficiency in the health service. If commissioners, health professionals and patients agree that the best value for money care can be commissioned outside the NHS, then it is not for governments to intervene, so long as their decisions do not

undermine the ability of the NHS to perform its core functions.

3.1.4 This does mean that public and private providers must be treated equally. For example, highly skilled and properly trained staff are vital to the provision of high quality services. At the moment the NHS bears almost all the costs of training health staff, although many are subsequently poached by the private sector. In Policy Paper 9, *Working for Change*, (1994) we proposed an easily administered remissible training levy for all large firms, including private health care providers, equivalent to 2% of a companies' payroll, minus their approved expenditure on training.

## 3.2 A National Inspectorate for Health Care

3.2.1 In order to ensure that national standards are met across the country and across the whole range of services and providers (including private hospitals) Liberal Democrats would establish a National Inspectorate for Health and Social Care.

3.2.2 This proposal was first developed in *Restoring the Nation's Health*. In addition we proposed in *A Caring Society* to make the current Social Services Inspectorate independent of the Department of Health. In the light of our clear commitment to merging health authorities and social services departments it is clear that our ultimate aim should be to merge the two inspectorates. The new Inspectorate would be centrally funded and work alongside, not within, local health and social services boards. Its responsibilities would include:

- The enforcement of standards in health and social services.
- Detailing the improvements services require in order for them to meet the standards laid down.
- The closure of facilities that consistently failed to meet those standards.

- Publication and circulation of advice on good practice, successful innovations, training opportunities and environmental protection.
- Advise ministers when standards can or should be improved

All the Inspectorate's reports should be published unless, by so doing, patient confidentiality would be breached.

3.2.3 In addition to regular inspections, some without notice, the Inspectorate should also be able to respond to requests for inspections from patients, their relatives and members of staff.

## 3.3 Barriers to Improving Standards

3.3.1 At present, only 15% of UK hospital in-patient medical procedures have proven beneficial outcomes, which is not to say that the others do not, but that no work has yet been done to evaluate them. Liberal Democrats believe that 'Quality costing' of health procedures must be further developed as quickly as possible to ensure that the financial costs and benefits of all NHS services can be demonstrated by means that are scientific and capable of audit, whilst taking care not to deprive patients of new treatments.

3.3.2 However, before anyone can make decisions about improving spending in particular areas of the Health Service much more information is required on the costs involved. The inability so far of health service assessors to arrive at an agreed definition of need, to assess the incidence of quite common conditions, or to establish an effective costing methodology, makes it impossible to judge how rapidly need is expanding or to assess how expenditure might be contained. Without a clear costings methodology or definition of need health budgets will, in effect, be set arbitrarily, driven by taxation, other social policies and competition between spending departments, rather than by rational consideration of health outcomes

# Funding the NHS and Setting Priorities

**4.0.1** The proportion of GDP spent on the UK's health service has risen from 3.9% in 1960 to 6.2% in 1990, although the rise over the last decade has been only 0.4%. This level of health spending as a percentage of GDP remains the lowest in the European Union; in 1990, Spain, the next lowest, spent 6.6%. The European Union average was 7.8%. By contrast, the rate in Sweden was 8.6% and the rate in the USA was 12.4%. Comparisons between countries should, of course, be treated with caution, because like is often not being compared with like but, nonetheless across the developed world, the percentage of GDP taken up by health care is rising.

**4.0.2** Despite access to free health care over the last fifty years people's demands on health services have not decreased. This is in part a consequence of technological advances, and of demographic change. More and more people are surviving into very old age - a time when a significant proportion of people has an extremely high 'need' for health care. However, it also shows that the people of Britain are often no healthier than they were fifty years ago and many are less healthy. In this sense the National Health Service, in all its guises, has failed. It could be argued that the very act of making health care free to all has led to people taking less responsibility for their own health and passing on to government.

**4.0.3** The Conservative Government has allowed the NHS to opt out of long term health care under the guise of the Community Care legislation. The Conservatives have, thereby, created means tested long stay medical care.

**4.0.4** If these factors are causing a problem with funding then the government, any government, should say so. Much of the reasoning behind the Government's changes to

the NHS was to divert attention from the real issue and, therefore, stifle debate.

## 4.1 The Liberal Democrat Approach

**4.1.1** Liberal Democrats remain convinced that, in part, improvements in the quality and extent of health services remain dependent upon increased funding. However, they are also dependent upon a proper assessment of the value of current expenditure. In the short term, therefore, we believe the priorities are to:

- Ensure that the funding is available to meet the long term health care needs of patients regardless of age and whether they are in hospital or in the community.
- Review health expenditure across the whole spectrum of social policy - the environment, housing, education, the distribution of wealth and so on - to improve not just *standards of health care* but also *standards of health* (see Chapter 1);
- Improve the level of information about the costs and benefits of health care (see paragraph 3.3);
- Increase public involvement in determining the overall level of funding for health care and the NHS (see paragraph 4.4).

**4.1.2** In the longer term we believe that spending will need to rise in order to meet the growing demands on the Health Service. The options for providing these extra resources are:

- Increased funding through higher taxes.



- Redirect spending within the NHS through prioritising assessed needs.
- Reduce demand by taking a comprehensive approach to promoting health.

## 4.2 Increasing Revenue

4.2.1 Liberal Democrats believe that the National Health Service should continue to be funded from general taxation and that its resources should be increased in line with the growth in its costs resulting from demographic change and technological advance. However, even such increases will not make it possible to tackle the unequal provision of certain services or improve the overall quality of the care provided by the NHS.

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**Liberal Democrats believe that the long term financial security of the NHS demands effective action to promote a healthy society.**

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Whilst we still believe that the Health Service deserves increased funding from general taxation economic reality means that such increases are going to be negligible for the foreseeable future. Furthermore, with the breakdown in trust between the government and the electorate on the raising and spending of taxes, support for significant increases in taxation to meet welfare needs is limited.

4.2.2 The Liberal Democrats' response has been to consider hypothecating, or earmarking, taxes, for particular services. This would give taxpayers a guarantee that particular tax revenues would be directed to particular services. As part of the process of rebuilding trust and to provide extra resources we propose to earmark revenue from increased tobacco taxes to health care.

4.2.3 Smoking costs the National Health Service an estimated £610 million per year: the

cost of treating cancers and other smoking related diseases (*The Smoking Epidemic: A Prescription for Change*, Health Education Authority, 1993). Fifty million working days are lost to smoking related disease every year. It contributes to asthma and pollution. Above all, it kills people: one in three of its users.

4.2.4 *We will increase tobacco taxes and earmark the extra money raised to contribute to better health.* Furthermore, we will press for similar price levels throughout the EU, in order to prevent the avoidance of UK duties through the buying of tobacco products elsewhere in the Union, and for the abolition of EU subsidies to tobacco growers. Just five pence added to the price of a pack of cigarettes would yield an extra £200 million - enough to pay for the abolition of eye and dental charges at a stroke.

4.2.5 *Of course, the main purpose of increasing taxes on tobacco is to discourage smoking.* This approach has proved successful in Canada, Victoria State in Australia and is encouraged by the World Health Organization.

4.2.6 As a result of earmarking extra tobacco tax revenues to the NHS we would be able to reinforce our health promotion campaigns. The measures it would enable us to take could include:

- Abolition of charges for eye and dental checks.
- Freeze and review the level of prescription charges and reconsider the current exemptions.
- The funding other urgent measures identified as priorities for promoting better health, over and above those which could be funded from increases paid for from general taxation (see Chapter 1).

4.2.7 Furthermore, less smoking will bring a healthier environment and reduce the amount the NHS needs to spend on smoking related illnesses, thereby releasing money which can then be spent on cutting waiting lists, reducing charges and treating patients.

## 4.3 Setting Priorities

4.3.1 In order to be able to set priorities and contain expenditure we must have a clear idea about the costs and benefits of health care and the value for money of the services that are provided. The key to getting value for money from the NHS is the creation of mechanisms for assessing the cost-effectiveness of different ways of providing health care. For example, scientific advances and new technology may well require significant initial investment, but may, in the longer run, reduce costs and improve quality by enabling more surgery to be carried out as day care. Such options must be carefully examined, with mechanisms taking account not just of the health 'gain' in terms of keeping a patient alive, but the quality of life which treatment can produce.

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***Putting over a million people on waiting lists is no longer an acceptable way of setting priorities.***

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4.3.2 As stated in section 3.3 much more work needs to be done in both the effective assessment of health care needs and demands, and the 'Quality costing' of health procedures. Without such information it will not be possible to determine where the major health care needs of the nation lie and which services meet those needs most effectively. However, such information, when it is gathered must not be based simply on costs to the NHS but also on the wider impact of poor health on an individual due to, for example, resulting unemployment and demands on social services.

4.3.3 Even if it were possible to determine a specific amount of money which would enable the NHS to meet all the nation's health demands in full, it is unlikely whether such a level of funding would be politically acceptable, with or without the use of earmarked taxes. Any responsible party must

therefore consider ways in which priorities are set for health expenditure, recognising the unlikelihood that all the demands on the health budget will be met.

4.3.4 'Rationing' or 'priority setting' already exists in Britain, through a combination of waiting lists and health service charges. Such a method of priority setting is unfair, secretive and often illogical. It also doesn't work. Cure takes priority over prevention. Those who can afford to pay understandably skip the queues. Who gets treated and who doesn't is determined by a very few health professionals. Most patients have few ways of influencing decisions and inadequate opportunities to complain when the decisions seem unfair.

4.3.5 Liberal Democrats consider that putting over a million people on waiting lists is no longer an acceptable way of setting priorities for the NHS. We are determined to develop a new method of priority setting in the NHS.

## 4.4 Involving People

4.4.1 Liberal Democrats have considered various ways of setting priorities, including looking at the Oregon experiment in the United States. There, all medical and surgical procedures were carefully listed in order of priority after consultation with the people of the state and medical and nursing staff. Whilst Liberal Democrats applaud the openness of this process we are concerned that it could prove dangerously simplistic. Priority setting involves making difficult and contentious decisions and these must not be determined by prejudice. Liberal Democrats believe that any form of priority setting that is established should involve the careful consideration of the following:

- The health needs of the population as a whole, rather than on the ability of individuals to pay for treatment.
- The comparative benefits of each health procedure to the entire population.
- The severity, not just the incidence, of any particular condition.

- The impact of any health procedure on the quality of life of the recipients.
- The views of the public.
- The views of health staff, including doctors and nurses, medical social workers and managers.

4.4.2 Liberal Democrats believe that the public must be more involved in setting priorities for the NHS. We propose to:

- Bring health commissioning within the scope of locally accountable decision-making (see Section 2.2).

Make greater use of focus groups, opinion surveys, citizen's initiatives or advisory referenda in setting health service priorities. (These techniques are already used in a number of Liberal Democrat-controlled local authorities and some health commissioners.)

4.5.1 Through the involvement of the public in the decision making and priority setting processes of the National Health Service

Liberal Democrats believe that people will become increasingly aware of the costs of health care. Consequently, we believe people will begin to take more responsibility for their own health and lead healthier lifestyles.

4.5.2 Liberal Democrats believe that the long term financial security of the NHS demands effective action to promote a healthy society. In chapter 1 we reaffirm our commitment to such action that we first laid out in Restoring the Nation's Health. Through health promotion Liberal Democrats aim to reduce the demands upon the Health Service. This is a long term aim, but unless action is taken now, increasingly tough decisions will have to be made on the prioritisation and rationing of services. There will be increasing pressures on the NHS to become less of a national service and more a safety net for those who cannot afford private insurance. This is not the future the Liberal Democrats want to see for the NHS. We are determined to build on the best of the NHS, to put patients first and to create a modern health care service fit for the 21st Century.

*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 Party in England and Wales.*

*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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