PROVOCATION #3

NOVEMBER 2023

RADIX BIG TENT

A NEW SOCIAL CONTRACT FOR BRITAIN'S HEALTH

FOREWORD

We have to talk about Britain's health.

Yes, it is widely understood that the NHS is in collapse: broken not just by the pandemic, but by over-centralisation and the ever-growing costs of acute treatment.

Everyone agrees that the NHS is heading for (on?) the rocks and still it soaks up every last penny… while the health promotion, education, quality housing and social care essential to live better for longer have been starved of resources.

This can't continue, for reasons of demographics, finance and expectations, yet mainstream political discourse about health has become totally circumscribed. Reform is seen as necessary but politically impossible and the very size of the challenge means that any proposed changes are either too small to make a difference or too large to be implementable. Tackling the problems of Britain's health are, to abuse a cliché, like trying to "boil the ocean".

We do not pretend for one minute that the measures proposed in this paper are the cure for all such ills, but what we have aimed to do is identify a framework within which to hold the right discussions, and a number of practical proposals that could at least open up new options and a different way forward.

Some of these proposals are controversial; some perhaps politically unachievable - for now at least - but if we shy away from even having the debate, it will soon be too late.

We hope our political leaders will be provoked to rise to the challenge and encourage everyone who cares about the future of Britain's health, to give them to space to do so.

Ben Rich
Radix Big Tent
Chief Executive

"The difficulty lies not so much in developing new ideas as in escaping from old ones."

John Maynard Keynes

INTRODUCTION

It has to be said. The current UK healthcare system – our much-loved, much-derided National Health Service – is broken.

The crisis did not begin with Covid, but it seems to have been the straw that has broken the camel's back. The upside is that it has unleashed a wave of initiatives to get the health system back on track – from Sajid Javid's call for an honest debate about the future of the NHS to Wes Streeting's recognition that structure as much as cash will be the answer to the NHS's problems – not forgetting the decision of The Times to set up its own Health Commission to make recommendations to government. All these point to a debate that is already well under way.

So, the good news is that the NHS is no longer beyond questioning. And yet the debate still seems to be severely circumscribed. To criticise health professionals or suggest that health funding in the UK might be better managed or differently prioritised is to risk the public wrath. And to suggest that some other mechanism than general taxation might be used to fund even a tiny part of healthcare is sacrilegious.

And yet, as Prof Stephen Smith pointed out in the first in his *The Best NHS?* book series for Radix, the demands of the NHS today are entirely different from those originally envisaged by Beveridge. Life expectancy has grown substantially and the range and quality of treatments available have increased beyond imagination.

Many of us are also able to live on for years with illnesses that might reasonably have been expected to kill us within a matter of weeks or months in the 1980s and 90s, let alone in the 1940s and 50s. As a result, many of us have complex medical needs resulting from several comorbidities.

The NHS today was not designed for such a situation and the truth is that it can't cope. Outcomes, except for diabetes, are significantly worse almost across the NHS than in comparable countries – even, in many cases, where the UK is spending more.

There is a serious shortage of staff in almost every discipline across the service.

What's more, the situation is only going to get worse. Medical sciences continue to advance offering new treatments and expenses. As we age, the percentage of the working population available to contribute to healthcare is shrinking. Meanwhile, the capacity of social care has been hollowed out, placing an ever-greater burden on primary and acute health care services.

The combination of all these issues – poor outcomes, unequal access, unhappy patients and staff, and the way they are so geared up to treat ill people without keeping us healthy – taken together are politically unsustainable.

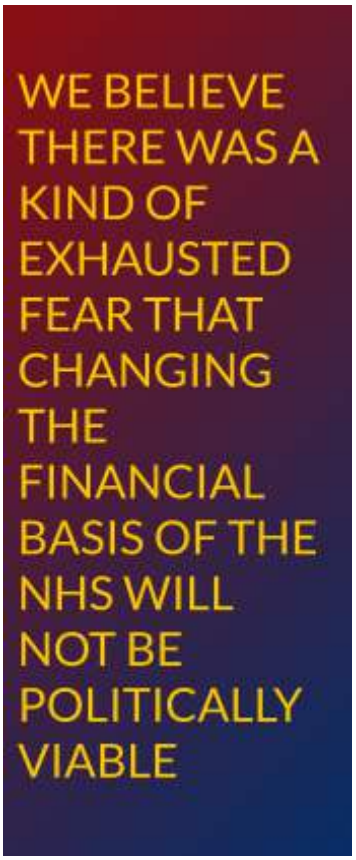
It is also going to get worse.

Demographics are against us – the current model is financially, socially and politically unsustainable – compounded because we can't even discuss this.

We need to challenge the mythology of the NHS: the idea that it is – let alone must forever remain – free at the point of delivery, or that the only alternative is a disastrous American non-system.

That is why we are calling for a Royal Commission – an honest discussion about what is possible, given the demographics and other issues – leading, we hope, to a new social contract for healthcare in this country.

Background and Starting Principles



So, we start this pamphlet with the following principles:

1. **The NHS is broken** and may be beyond repair in its current form.

2. The most urgent priority is to end the current unthinking mythology about the NHS. **It isn't true either that the NHS is the envy of the world, nor that it is the only alternative to a dysfunctional, failing American system**. Nor that it is the only system in the world which allows all citizens to access healthcare for free at the point of use – nor even true that the NHS manages to deliver this.

3. Bearing this in mind, we believe that **any charges which do exist must not be at the expense of access for all** and cost should not be a deterrent to individuals seeking appropriate and effective healthcare.

Our objective is to create a new social contract for Britain's health, focused on shared responsibility for keeping healthy, better outcomes for sick people, fairer payment and equality of access.

This paper represents the work of four top level roundtables on different aspects of reform of the NHS, including key politicians, academics, entrepreneurs and health professionals. It also draws on Stephen Smith's book series, *The Best NHS?*, published by Radix.

Not everyone involved in our roundtables will agree with everything in this document. Indeed, some did not even agree with our first starting point, but we were able to have constructive and civil conversations, which are the important first step for health discussions.

There was widespread praise for the Dutch health system, where the first 30 percent of costs are underwritten by the government. Then everyone is required by law to buy an insurance package - though how much one buys is up to them. For example, one individual may choose to add dental, etc. The insurance companies act as gatekeepers, they get charged a fraction of the price, and the rest is subsidised by the government.

Even so, we believe there was a kind of exhausted fear that changing the financial basis of the NHS will not be politically viable.

We all have contributions to make: we need encouragement to take more responsibility for our own health.

We need a new social contract based on the individual. Then we need to get clinicians on board, and to get figures like trade unions and city leaders - especially in areas of deprivation - to support the social justice arguments.

We need areas of commerce supporting the economic arguments. We also need voters and patient voices to think about how individuals should be responsible for their own health. Clinicians themselves will need to be convinced. The end result should be a new social contract between citizens and their health system.

The contract needs to include the role of communities, in collaboration with the state. Communities can run libraries, leisure centres, raise revenue from the community that is unreachable by the public sector.

And the social contract goes both ways. NHS founded, cottage hospitals set-up by the community were adopted into the NHS. Now the NHS no longer needs these cottage hospitals, it is trying to sell them for best commercial value rather than giving back to communities.

We need to make sure it is an equal partnership with the community, instead of raising revenue on the cheap. In other words, the new social contract need to incorporate three elements:

- **Individual responsibility**: to look after ourselves, live a healthy lifestyle, turn up for appointments, pay our way.

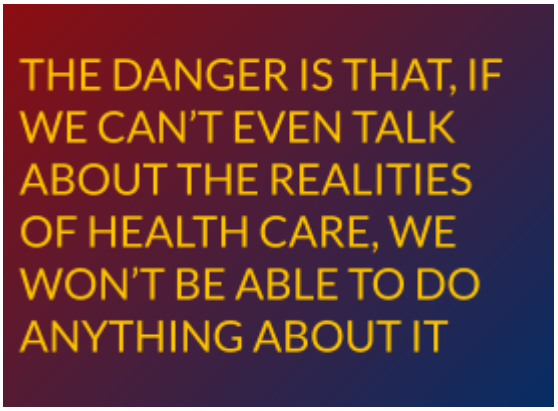
- **Government responsibility**: to create an environment which is clean, deals with mouldy homes, tackles junk food, obesity, smoking etc, embraces technologies, vaccines, genomes etc, and invests in the workforce.

- **Community responsibility:** the responsibility shared for looking after neighbours, friends, family, and to make sure through our own efforts that local health resources are used efficiently.

Section I: Individual Responsibility

Nobody wants to talk about the fundamentals: the ageing population, the shrinking working population, the cost of innovation in healthcare, and increasing expectations that we should get everything we want under the NHS. Combine all of this – and the NHS in its current form is simply not affordable. Yet, politically, it is unacceptable to say any of this.

The danger is that, if we can't even talk about the realities of health care, we won't be able to do anything about it.



Our proposal is a new social contract which starts with individuals taking responsibility for their own health decisions. At the moment they are prevented from doing so by a lack of information or options, a culture of secrecy and centralisation, and an underlying assumption that decisions about our own health issues are for professionals rather than ourselves, our families and our communities.

How could we change this?

- **Change the language:** For a start, we need to lose the term 'free healthcare' – nothing is free. The question is really "who will pay for it, how and when". Only then can we ask if this is the fairest, safest and most efficient model or whether there should be a baseline for what is free, when to apply means testing, and when to charge for referrals or services.

- **Increase transparency:** We need to know how much money is spent on assessing patients and getting the treatment. We need to understand the difference between spending money early and spending it late. We need to know the costs of delayed treatment, and we need to audit treatment outcomes.

- **Understand ill-health**. We need to stop over-diagnosing ill-health, which means longer waiting lists, and that people who really need help miss out. We need to understand the difficulties caused by 'frequent flyers' who swamp primary care services and the impact they have on others' access to care. It means teaching resilience and pastoral care in schools, work and health settings. It means providing more general access to mental health services for children rather than using long drawn-out assessments to ration care based on limited diagnoses.

- **Promote good health**: The current disease-centric model of care is deeply unhelpful, often leading to patients being shunted around between narrowly focused specialists with no one person tasked with

taking a holistic approach in the overall interests of individuals. We need to understand the value of social prescribing to promote good health, prevent illness, detect problems and treat early, as compared with acute care and management.

- **Tackling the culture of disempowerment:** The NHS culture has resisted internal change for decades. We need to compress the proportion of lives spent in ill-health, helping individuals to make reasoned judgements on how they want to live, and die. We need to engage individuals co-designing services leading to higher quality provision of care, less inefficiencies and less waste because people get what they want, not just what the system is designed to provide.

In short, we need to encourage and help people to take more responsibility for their own health.

Section 2: Government Responsibility

But individual empowerment, while important, is not enough. The Government has to be ready to do more to manage services effectively and in the round.

Because of the paucity of series debate about health care policymakers focus only on a very narrow landscape of reforms largely concerned with reducing waste in the system. That isn't hard to find: poor administration, poor communications, and so on.

Yet much of this has been caused by under-investment over decades, which leads to people missing out on services and which probably ultimately leads to more spending rather than less. So "reducing waste" becomes an excuse for avoiding real reform.

Instead, a new social contract needs to:

1. Fair charges for those who have not paid into the system: While there is no consensus for introducing general charges for UK citizens for healthcare, there are plenty of sensible measures that can be taken to increase funding without breaching this principle. As a first step, we should, however, review the criterion for eligibility for free care, as well as the level of charge, for some visitors to the UK and those returning to the UK specifically for treatment. This should include introducing charges for care equivalent to those within the visitors' normal countries of residence for services such as GP consultations, A&E visits and family planning. Where reciprocal agreements exist, hospitals need to be properly incentivised to recoup fees from the country of origin. International students do currently pay a fee of £470/yr for treatment. This figure should be reviewed as a matter of urgency.

2. Reconnect national insurance contributions to paying for the NHS. There is an understandable expectation that national insurance contributions should help to pay for the NHS. In fact, they cover only about 10 per cent of NHS funding. At present, pensioners who continue in work or self-employment stop paying NICs on reaching the state pension age. This often coincides with the point at which they begin to make more use of the NHS. We should consider continuing to seek a contribution to national insurance by working pensioners.

3. Reduce or remove NHS charges by increasing NICs and the levies on private healthcare providers. Despite the widely held belief that the NHS is free at the point of delivery, numerous charges exist, for dental care, optical care, prescriptions, for example, and so on. These create huge inequalities and discourage hard up patients from seeking the care they need. NI contributions should be increased for higher rate taxpayers with the aim of restoring the principle of the NHS being free at the point of delivery. Income could be supplemented by a levy on non-charitable private health providers.

4. Organise for better management: Service managers are the first cut when savings are needed, but managers run the hospitals. We need to ask how we make management better and more effective before we ask if we can reduce costs.

5. Introduce a system of online bookings for consultations and treatment slots, with the most popular times subject to a fee. This would encourage the use of facilities, such as operating theatres, for more of each day. The NHS should offer a supermarket delivery-style system to enable patients to pay extra to book treatments at times which suit them. The system must not enable patients to secure quicker treatment by paying, but simply to book a slot at a time of day which is convenient to them in return for a fee.

6. Create more academic health science centres and an innovation culture. The UK is potentially the best source of medical data in the world. We should work with the Medical Research Council, charities and universities to continually look for ways to monetise clinical trials, exploit innovation and IP. We should be using analysis of aggregate anonymised data from the NHS to form joint ventures.

7. Integrate with local government, or at least work more closely with them. Local government has always had a shadow role to play in the delivery of health - especially in tackling childhood obesity, type 2 diabetes. Now they have a joint commissioning role, yet life expectancy for the poorest is going down and child mortality is increasing. And because of the cuts to local government budgets, costs have moved upstream to high-cost hospitals.

8. Encourage entrepreneurial approaches by local providers. We need to be prepared to let local trusts be more entrepreneurial without being accused of attempting to privatise the NHS. And we need local providers to work out how best to handle mental health referrals.

Funding

Government's first priority is to ensure that our health service is properly funded. It is clear that we will need to increase the funding to the NHS for the reasons given earlier in this document. Some of these extra costs can be offset by the reforms proposed described above. Some will definitely be offset by a reduction in the costs of treating people in the way they are currently treated.

Even so, it seems unlikely that this will be enough even in the short-to-medium term, let alone in the long term. To ensure that funding is sustainable over time, the central responsibility of Government in the new social contract for health is to:

- Sort out social care along the lines suggested by Dilnot, as part of the integration of social care

into the NHS and the merger with local government.

- Settle the remaining industrial disputes with health professionals.
- Empower local providers to save and raise money within the principle of an NHS free at the point of delivery.

Section 3: Community Responsibility

It isn't just individuals or Government who need to take more responsibility for health - we also need to find ways that communities can step up to take more responsibility for the treatment of family, neighbours and friends, working with primary care providers, the voluntary sector and community groups. This means:

1. **Break down the structure of the NHS.** The NHS is quite simply too big to manage: you can't even email everyone in the NHS, because it comprises around 16,000 organisations. So a first step in NHS improvement must be directly linking local NHS organisations with the local voluntary sector, and sharing resources to make sure that people are looked after.

2. **Build a co-productive partnership** whereby every health institution is fully embedded within its local community and primary care providers, community pharmacies and the local voluntary sector work together to support self-help and social prescribing. We can use community pharmacies to make community-based care a reality, which means directing patients towards how to take more control of their own health - especially those with chronic conditions – and encouraging patients to trust themselves and each other.

3. **Shift resources.** Many 'productive gains' for the NHS depend on making better use of digital technologies to deliver care, but for many of the groups that most depend on the NHS – the most vulnerable, elderly and those in left behind communities – this makes matters even worse. We know that early access to care saves money in the long term so we need to shift resources now to support the steps proposed above.

OUR NEW SOCIAL CONTRACT FOR BRITAIN'S HEALTH

Individuals, government and communities must share responsibility for keeping us all healthy, providing better outcomes when we fall sick, and ensuring that need rather than funding determines the care we each receive. This requires:

1. A grown up discussion about the **fairest, safest and most efficient healthcare model possible** rather than a dishonest political slagging match about privatization and spending levels.

2. **Increased transparency** so we understand what things really cost and how they work.

3. Promoting and **supporting good health** rather than focusing on diagnosis and late treatment.

4. Tackling the culture of disempowerment by **co-designing services and empowering individuals** to make their own choices about their lives and treatments.

5. **Fair charges for those who have not paid into the system**, especially visitors to the UK and reconnecting national insurance contributions to pay for the NHS.

6. **Better, rather than reduced, management in the NHS**, through a focus on training and recruitment.

7. **More academic health science centres** and an innovation culture to make the most of the UK's outstanding medical data.

8. **Empowering local government** to provide for and support local health and encourage local providers including local authorities to be more entrepreneurially.

9. Sort out social care along the lines suggested by Dilnot, as part of the **integration of social care into the NHS** and the merger with local government.

10. Build **a co-productive partnership whereby every health institution is fully embedded within its local community** and primary care providers, community pharmacies and the local voluntary sector work together to support self-help and social prescribing.

What Next

And what can we do now to establish a new social contract:

1. Hold an **honest discussion about reforming health care** in this country, allowing for the possibility that the NHS might need fundamental reform.

2. Launch a **non-partisan Royal Commission** to set out how we get to a different sustainable funding system for the NHS.

3. Demand of politicians across the main parties that they show **the political leadership necessary to allow space for such a debate**.

www.radixuk.org

hello@radixuk.org

14 Sandringham Street
York YO10 4BA

Registered educational charity
1167393