Speech to be delivered by Rt Hon Stephen Dorrell MP to REFORM Conference
Coordinated health and social care:
What would it take to really make it happen?
1st July 2014

Embargoed to 1st July 2014 12.00pm

FACTS AND FABLES IN HEALTH

“Things are not always what they seem; the first appearance deceives many; the intelligence of a few perceives what has been carefully hidden”.

So said Phaedrus, the Thracian slave, who was freed by Augustus and was responsible for translating Aesop’s fables into Latin.

Not a bad place to start when trying to disentangle truth from fable in health policy.

Fables involve what Coleridge later described as the endeavour “to transfer from our inward nature a human interest and a semblance of truth sufficient to procure …. that willing suspension of disbelief …. which constitutes poetic faith".

Consider the opening ceremony of the London Olympics. It was a great spectacle which very properly celebrated values and achievements which are important to us as a nation. We all felt better about ourselves and our country at the end of it.

But it was a fable. It asked us to suspend disbelief and join in a poetic statement of our aspirations.

That doesn’t mean it was wrong or illegitimate. Quite the contrary. It was what is was intended to be – a poetic statement of our aspirations.

Aspirations which are of course intensely political. Not party political, because they are shared across the political spectrum, but political in the sense that health policy impacts directly both on communities and on individuals at all levels.

Fables not a good basis for policy

But good policy cannot be based on fables. We need to be more straightforward with ourselves. We need to be willing, step by step, to disentangle truth from fable.

Let’s begin with objectives.

The fable is that NHS represents something that is uniquely British. Even those who believe that to be a true statement seem unclear about precisely what it is that is uniquely British about NHS values, but they are sure something must be.

Of course it is true that our health bureaucracy is unique to Britain but I am not sure what that proves. French and German health bureaucracies are unique to France and Germany – just as Departements and Laender are unique to their respective countries. Every country inherits and develops slightly different institutions.

But surely the striking thing about health policy is not the exceptionalism of the British, but rather the universality of the aspirations that were expressed in Danny Boyle’s spectacular.

Indeed that is why it was so successful. The whole point of the Olympic Games is that they are intended to encourage us to celebrate the things we have in common as human beings, rather than the things that divide us.

Access to healthcare is political

In almost every country in the world the application of modern technology to the prevention and treatment of disease has made possible dramatic improvements in health and wellbeing. Not surprisingly a common theme in the politics of every country is their people’s aspiration to secure access to those benefits on a basis which they regard as equitable.

Most famously, Obamacare has been the dominant domestic political issue in the United States since 2008, while in every European country access to health and care remains central to both budgetary and social policy. Further afield the Chinese government is increasing investment in prevention and community based services, and the BJP focussed in the Indian election on the need to address health inequalities in Indian society.

Far from being distinctively British, the truth is that the commitment to secure equitable access to the benefits offered by modern technology for our health and wellbeing is a universal human aspiration.

Which is why health is inherently political. The definition and expression of aspiration is part of the purpose of politics. A society which cannot define its aspirations is unlikely to achieve them.

But what we are doing about it?

Commissioning is key

Despite the frustrations of our experience I continue to believe that the role of the effective commissioner should be at the heart of the answer to that question. But what does the phrase “effective commissioning” mean? What does an “effective commissioner” look like?

The answer, I believe, is “nothing like what we have seen so far”.

Throughout the game of musical chairs imposed by successive governments, NHS and social care commissioning has been obsessed by process. Endless contractual processes seeking to define every detail of the answer but almost no attempt to understand the question.

To my mind effective commissioners should focus on understanding the problems they are trying to solve. They should talk the language of priorities and be open to all comers who believe they have a solution to offer. They are not system planners, and they should be more careful to avoid the trap of second guessing the management of care delivery.

We should be clear – innovation comes from producers. It is producers in any industry who are best placed to know how need can be met – and it is for commissioners to secure equitable access for their communities to the best solutions available.

What drives commissioners?

The prime focus of commissioners should be the needs and wishes of the individuals and communities they serve.

But is that really what drives commissioners in our system?

The reality is that fragmented commissioners have focussed more on process than on outcome and have largely failed to lift their eyes from individual transactions to consider health policy in its broadest sense. In a word they have proved unable to see the wood for the trees.

The inherited nonsense of the distinction between health and social care is a good example.

The fable is that healthcare in Britain is tax-funded and that it is therefore different from other forms of care and support which families, individuals and communities provide for themselves in order to improve their health and wellbeing.

But this approach is completely circular. Healthcare is what is the NHS does. The NHS is largely free. Therefore healthcare is largely free.

Who’s kidding who?

This view of the world depends on the fiction that there is a difference between the care and support provided to an elderly person by an NHS nurse on the one hand, and a nurse employed by a social service department, a domiciliary care provider or a residential care home operator on the other.

The inadequacy of the analysis is neatly illustrated by the endless attempts to define when an individual's requirement for continuing care is healthcare and when it is social care.

It's a process that has no more chance of producing a conclusion than a Becket play – for the simple reason that it is seeking a distinction where there is no difference.

Individual and collective responsibility

But the much discussed distinction between healthcare and social care is not the only, or even the most important, distortion introduced by our current arrangements.

Even more difficult conundrums can arise from the belief that all healthcare either is or should be free at the point of delivery.

At this point the argument normally goes off into assertions that the NHS funding model is unsustainable and that we shall have no choice but to extend the principle known to policy wonks as co-payments and the rest of the world as charges.

Relax. I'm not going there. Not because I daren't, or because there's an election due in less than a year, but because I don't agree with the argument and I think it is a dangerous distraction.

I don't agree because the argument is based on the unstated implication that other countries' systems rely more directly on price mechanisms to balance supply and demand for care, and that this leads to better value and better outcomes.

The facts simply don't support this assertion.

There is the conventional argument that the NHS model delivers relatively good value when health outcomes are compared with the resources consumed.

But there is a more important point.

I have already pointed out that, far from being distinctively British, the desire to deliver equitable access to the health benefits offered by modern technology is a universal human aspiration – reflected by political systems in virtually every country in the world.

Issue faces all societies

No society is content with the principle that access to good healthcare is determined by the patient's ability to pay; in virtually every country, institutions have grown up, the purpose of which is to secure a more equitable basis for access to care.

The details differ: we have the NHS; continental Europeans have social insurance; and the Americans have managed care. But the function in every case is the same.

It is to act as what we would call a commissioner – using a collective budget to secure improved health outcomes for a population.

Which is why I think the argument about which is the ideal funding model is a dangerous distraction from more important challenges which all commissioners face in common, whatever the basis on which they are funded.

At the heart of those challenges is the relationship between the commissioner and the individual patient or service user – people in plain English.

Spending on care will rise

I have said many times, and again at the weekend, that throughout human history, as societies get richer they have spent devoted a rising share of their increased resources to caring for the sick and the vulnerable. It would, in my view, be an extraordinary denial of our humanity if that were not true.

We should not therefore be surprised if economic recovery means that spending on care services resumes its upward trend; if it did not it would have broken a trend which has 5,000 years of recorded human history to support it.

Not only a question of how much? Also a question of how?

But it isn't just a question of how much we spend. It is also a question of how we spend it. The scale of the resources and organizations at their disposal means that commissioners risk undervaluing the contribution that individuals and their families make to their own health and wellbeing. It's what economists call "crowding out".

It is too easy to make the mistake of believing that healthcare is what the commissioner provides.

Reality is much more complex. Millions of people exercise consumer choices which are motivated by health considerations. Food selection and gym membership, together with choices about exercise, and tobacco and alcohol consumption all reflect people's interest in their own health, just as the choices carers make about their own time, and often their own careers, reflect their commitment to provide proper care to their family or friends.

These are not the choices of statutory commissioners, but they are choices which directly affect health outcomes.

These private choices reflect a challenge to commissioners to learn the value of humility. They must ensure that the services they commission work with people, and respect their choices, rather than simply applying protocols of professional best practice.

The commissioner’s role is to coordinate collective resources in a way which supports private choices as well as targeting them towards identified need. Neither private nor collective commitment can supplant the other; both represent essential elements of the health and care package.

Which brings us back to the relationship between the different statutory commissioners of care services.

Single commissioner essential

It used to be argued, and I have argued it myself, that the separation of healthcare and social care is inevitable because NHS care is largely free at the point of delivery and social care is means-tested.

But if the purpose of care is properly understood this argument is clearly wrong.

It isn’t just that a single commissioner of care services offers the prospect of more joined up services for individual users – although that is true. It’s more important than that.

Good health policy requires a partnership between private choices and collective commitment, and the belief that there is any part of health care which can be delivered on the basis that it is exclusively a collective commitment is an intellectual dead-end.

Commissioners need to develop a new partnership with their communities which is based on mutual respect and engagement. Commissioners cannot afford to see themselves, or be seen, as dispensers of state charity.

Partnership between Commissioner and Community.

The partnership model opens the door to a different approach.

Firstly, by abandoning traditional demarcations, the commissioner is able to look beyond healthcare provision and focus on health.

Success is not measured in numbers of clinical procedures undergone, or even in objective clinical outcome achieved, but in the individual’s experience of life. The commissioner works with the individual to deliver his or her objectives – which for most of us starts with the desire avoid illness in the first place. Prevention should not be the appendix added to the policy when it is proof read before publication. It should be one of purposes for which it is written.

Secondly, the commissioner who works as a partner will aim to facilitate the individual’s choices, rather simply provide what is good for them. Different individuals will engage with those choices in different ways, but this principle which is often seen as being highly political is, in my view, no more than good practice.

Surely no modern doctor would contest the proposition that patients should be involved in decisions about their own care. If that is true of the specialist decisions supported by professionals, how much more true is it for the wider range of decisions taken by commissioners?

Thirdly, this new style commissioner will see an individual's need for care and support not as a support for medicine, but rather as the core activity of a system which is able to marshal high quality medical intervention when necessary.

It is an important reversal of the thought process.

In a care partnership medical care is available when relevant; it is not the central purpose of the system. Individuals are more likely to avoid "defaulting to doctor" because the system is designed to support the user, rather than to control access to the doctor.

Commissioners as agents of change

Finally, and more controversially, this approach to commissioning inevitably leads us to challenge care structures which grew up to meet the needs of a different generation. Their needs and priorities were different and the technology available to them was different so we shouldn't be surprised if the structures they developed are not well suited to our requirements.

That is the commissioner's task in every healthcare system in the world. The slogans and titles are different, but the substance is the same. If commissioners do not facilitate change, the objective of more equitable access to the benefits of modern healthcare cannot be delivered.

Our society is very familiar with the change process. Our expectations are different from those of our medieval forebears whose experience of life was of a seemingly ordered and unchanging universe. We live with change. We know that new technologies bring new opportunities and that the world changes to reflect them. We know the immense benefits which this dynamic view of life can bring.

But that doesn't make it comfortable. Ultimately we remain human. We flatter ourselves that we are rational beings, but in fact we often prefer the familiar, and there is always someone on hand to defend the status quo.

Furthermore scepticism is not wholly irrational. Experience has taught us that, in the words of Phaedrus with which I started, "things are not always what they seem". Advocates of change do not always deliver their promises.

Which is where the politics comes in.

Human affairs will never be simple, and arguments for change will always be caught up in the cross currents of competing agendas. But we should always remember that failure to carry through necessary change will always have a consequence, and very often it is the people whose voice is weakest whom those consequences are visited.

This is the other side of commissioning. It is important that commissioners work with individuals and respect the contribution that all of us make to the health outcomes we experience. But it is also important that commissioners carry out their responsibility to target resources on need.

If we allow an unjustified status quo to prevail the result is that resources are used to protect the powerful rather than improve the life chances for the people who were at the back of the queue when the opportunities were handed out.

Despite the whole operatic superstructure of rhetoric and bureaucracy of health policy we would have failed to deliver the purpose with which we started out and which was so memorably expressed by Danny Boyle. The fable would remain just that – a fable – and things would not be "as they seem".

CHECK AGAINST DELIVERY

For further information contact:
Clare Whelan 07785 903901
Whelanc@parliament.uk