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From: [REDACTED]
Sent: 14 January 2002 15:00
To: 'Derek.Wanless@hm-treasury.gsi.gov.uk'
Subject: [REDACTED]

Dear Mr Wanless,

I read your interim report with some interest. You have put together some interesting information in a very readable way. I would like to make the following comments.

1. Although I believe that the current taxation based system is the fair and cost-effective way of funding the health service, there are problems with it. In my view the following are some of the most important;

* because of the nature of the funding arrangements, the major users of the MHS are not necessarily the people who pay for it. Moreover, as there is no direct connection between use of the NHS and the paying for it - the notion of using the NHS responsibly so that everybody in the whole community can use it to a certain extent, has been partially lost. The culture of caring for each other which arose from the challenges faced by the UK people during world war 2 has been lost. Indeed most people when it comes to their own health now expect the NHS to meet their needs in full irrespective of the consequence to their neighbours. The classic examples of this include A&E services and the ambulance services.

* most people seem to think of the NHS funding systems as some sort of insurance system which means that in their view, they have contributed and therefore they are determined to get all the benefits they are due. Although there are some similarities, the whole philosophy of the NHS is different. It is the last bastion of the notion that we care of each other and that we wish to have a system in place that enables a reasonable level of care to be provided to those who require it. The reasons I am paying for the NHS is not because it is going to care for in the future but primarily because I wish to contribute to ensuring those in need today are cared for in some sort of way. I hope and pray that when I require health services, the community that I happen live in will feel the same. I think these notions are no longer in favour.

* I think this view is shared by many of our political leaders. Certainly in the way they lobby for individual patients/groups/causes, they are not interested in what the NHS is trying to do locally but only in the needs of that particular individual/group etc.

I could go on - but hopefully you will understand the point I am trying to make. I think there is a real need to debate the philosophical basis of the

NHS.

2. If I am right that the notion of caring for each other has been lost - I think you do need to consider other ways of financing the NHS - social insurance may be the most cost-effective way within the emerging culture of the UK. I do not think that funding can be seen in isolation to the general culture about how we see ourselves and the extent to which we care for each other. If the predominant culture is that each individual should take care of themselves but that we ought to have a safety net, then social insurance (this could be employer +/-employee based) maybe more cost-effective than that based taxation.

3. Equity is an important issue. However, one of the very difficult issues is the variability in clinical definitions of need as well as the ability to benefit from an intervention. Clinical colleagues vary greatly in terms of exactly when they would intervene for individual patients. An example will make the point; locally our cardiologists have decided that patients with heart attacks should have an emergency angioplasty if all else fails. As a result from a funding point of view, we are having to put in a great deal more into this service planned. This contrasts with our neighbouring HAs where these procedures do not take place and as a consequence they do not have the same level of spend as we do for this particular procedure. Thus they are able to spend the money in other ways which we cannot. Another example is the variation in GP referral rates which are primarily a reflection of the ability of the individual GP to manage risk.

4. Questions for consultation (chapter 7):

7.1 Principles: One of the key difficulties we have is the issue around - finite resources. Either we have to provide care to meet the needs of people within the resources available to us or we can plan to meet needs without taking any account of resources. The 2 approaches are not the same. Therefore the core principles as set out in the Plan are out of context. There should be a principle around implementing care that has been shown to cost-effective. There should be a principle around providing information on how the health status of people are improving as a result of investments. There should be a principle around equity and fairness.

The principles as set out in the plan are what the government could agree with the professions. As a consequence they cannot be termed principles in the conventional sense of the word.

7.2 Expectations; the NHS does not meet people's views about the quality of care. The physical environment, the way services are managed both within the NHS and by the Ministers, access to care, implementation of effective

treatments are all not very good. As a consequence, I think the community as a whole has been short changed. To my eternal shame I cannot even now stand up say that everybody in North Staffordshire with heart disease who is suitable for Aspirin is on it. I cannot even say when we would achieve it because the management systems in place do not concentrate on outcomes but on providing bits of services.

7.3 20 years time - I want a service that allocates resources fairly and cost effectively. I want a service that will make sure that if an intervention is seen as beneficial, will implement that intervention to the benefit of everyone who needs it. I want a service that will be "owned" by local people who will take on the responsibility of ensuring the service is used responsibly and not inappropriately.

5. Para 2.41 of your report - Implementing NSFs does require additional monies. This is an issue for parliament to debate and agree how quickly the NSF is implemented. For the management issue is about what the balance of investments ought to be between, promoting health (healthy eating), preventing disease (smoking cessation), diagnosis and cure (management of heart attack) and rehabilitation (stenting, revascularisation etc) in order to get the most value for the funds we have available. In my view the systems are such that this sort of approach cannot be implemented. One of the important points about statins and CHD is that one has to look at how the different medicines and other types of come together for individual patients.

6. Questions (Chapter 8)

8.1 I think one of the key issues is a good information system to help plan, monitor and evaluate services as they are delivered. In our patch one of the reasons the Staffordshire Ambulance Service meets response times is that it has an information which allows it to operationally manage ambulances on a minute by minute basis taking into account likely demand. A system which can do that for the hospital or primary care would lead to a different paradigm of operation.

8.2 A nother cost driver is the changing context for training doctors and the need within communities for such staff. I think this does need to be taken into account. Given that two thirds of the NHS costs are to do with people - manpower is an important consideration.

8.3 People have and will always want choice. The real question is how much choice will they be allowed to exercise. In my experience people want their particular problem sorted as soon as possible and most will co-operate fully to get that done. Problems arise when this is not possible.

7. Questions (chapter 9)

9.1 Changing needs - I believe that the major interventions of the last

decade has been in terms of keeping people healthy and in terms of delaying the onset of complications (including death). The latter will mean that we will have an increasing number of frail people who will require considerable support. The former should mean that the majority of the elderly will be relatively healthy and only require replacement parts as the eyes and joints "wear out". Over the longer term 30-40 years there will be compression of morbidity. In the shorter term - there will be an apparent expansion as the benefits of recent medical advances come into play.

The great unknown is the change in family structure which may mean that vulnerable members of our community will not have the social support they need to live in the community.

9.2 Life expectancy will continue to improve and particularly life expectancy for middle aged and the young elderly.

9.3 Health inequalities to a large extent depend upon inequalities in other areas such as education , wealth etc. Consequently, reduction in inequalities will depend to a large extent upon these other inequalities.

The crucial interventions are education, job opportunities and the extent to which one can maintain the notion of community.

8. Questions (chapter 10)

10.1 Medical advances are likely to increase expenditure both in terms of the technology itself as well as people to make it happen.

10.2 The most important advance will be around genetic manipulation. This has the potential to change the way we look at health. Clearly, the impact of the wider environment on health will remain and therefore the second issue is how the environment interacts with genetics. At one level this is about the social environment in which we live. At another, it is the physical environment, for example global warming.

10.3 I think the pace of growth in technology appears to be much faster now than previously. I am not sure whether this is a perception or whether reality. I think the pace is likely to increase because of organisations like NICE.

9 Questions (Chapter 11)

11.1 There will be considerable changes vis a viz doctors and other professions. The role of artificial intelligence in supporting patients and clinicians will also need to be taken into account. I think increasingly, nurses will form the frontline and play the role that GPs currently play. We will need doctors to support those nurses as well as provide specialist services.

11.2 Manpower planning has not been the strongest skill of the NHS. I think it would be better to aim for a surplus of labour. Trainees are increasingly being taken out of service provision which does mean that there is a greater need for qualified staff.

11.4 I think productivity gains are going to be much less in future years. I think doctors are generally no longer willing to compromise between numbers and quality. Moreover, clinical governance and the revalidation initiative will push doctors and other professions into spending more time with smaller number of doctors as well as into other areas.

11.6 I think patient involvement in their own care as well as others may be potentially very important. At one level, it is about enabling people in general to be competent in first aid, CPR etc. At another level it may be about enabling people to adjust their own treatments, for example in diabetes. The crucial elements are in terms of influencing the curriculum in schools as well as supporting individuals with chronic illnesses. The role of nurses and educationalists is very important.

10, Questions (chapter 12)

12.1 The issue is the relationship between health and deprivation (however one measures it). If deprivation varies, then health trends will vary. I think there is evidence to suggest that wherever you look health varies - the real issue is the extent of the variation. Those countries where deprivation varies within narrow limits and those with effective welfare provision appear to have less variation.

12.4 The issue of management is very difficult. In my patch 4 years ago we had 4 CEs, 4 Financial directors etc. From April 2002, we will have 8 of each. The advantage is that 4 will be looking after much smaller patches - however, it is difficult to argue that the cost will be balanced by the benefits. Having said that good management is crucial to the NHS. Currently, within the NHS there are 2 management organisations - clinical and the rest. If we are lucky they come together. The NHS has not been good in managing and supporting doctors achieve the best they can for the people in any one locality.

I hope this is helpful.

Yours sincerely


Director, Public Health



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