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## Health Crisis - What Crisis ?



*Proceedings of the Fabian /  
Socialist Health Association  
New Year Conference  
1996*

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New Year Conference, 1996

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1	<b>Introduction</b>	1
	Hugh Bayley, MP for York	
2	<b>What will Labour do ?</b>	6
	Kevin Barron, Shadow Health Minister and MP for Rother Valley	
3	<b>Past and present</b>	11
	Howard Glennerster, Professor of Social Administration at the LSE	
4	<b>Is there a crisis in health care ?</b>	14
	Anna Coote, Deputy Director of the IPPR	
5	<b>GPs-Fundholders or commissioners?</b>	18
	Dr Rod Smith, a fundholding GP in Reading and Dr Ron Singer, a non-fundholding GP in North London	
6	<b>The future of long-term care</b>	26
	Melanie Henwood, Independent Health and Social Policy analyst	

**Conference  
Directors :**  
**Hugh Bayley  
and Dr Tony  
Jewell**  
(Socialist  
Health Associ-  
ation)



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# Introduction

1

Hugh Bayley gives a summary of the conference's discussions

**T**his year's Fabian New Year Conference 'Health Crisis, What Crisis?' put the spotlight on Labour's document *Renewing the NHS* and built upon its proposals. An exciting and stimulating day saw eight major health themes discussed:

## *Objectives for the NHS*

Without clear objectives any policy is doomed. It will lack strategic direction, and be impossible to evaluate. There was consensus on two objectives: health policy should seek to achieve the maximum improvement in the health of the population, and to reduce health inequalities.

A third objective, accountability, appeared to be a means to an end rather than an end itself. The NHS ought to be accountable to patients and the public. According to Professor Howard Glennerster, a lack of accountability has always been a weakness of the NHS. It was set up as a nationalised monopoly on the Morrisonian model, and is therefore more responsive to producer interests (doctors primarily) than to consumers (the patients). Aneurin Bevan took the view that the equity benefits of a national service outweighed the producer bias of a monopoly, and he won the political argument. But in the 1930s many Fabians, such as Evan Durbin and Hugh Gaitskell, criticised the Morrisonian model, arguing that it offered neither choice nor voice to consumers. If the NHS remains a universal national service—and there are compelling political arguments for this in the current economic climate—NHS decisions must be made openly and those making them need to be accountable to patients and the public. This implies a limit on clinical freedom: doctors and other health professionals should be accountable to the public and patients for their clinical practice.

## *Cost containment v higher spending*

One further objective for the NHS was canvassed. Professor Alan Maynard wanted cost containment to be an objective for the health service.

The case against cost containment was put by Bob Abberley, a national officer of UNISON. The UK spends only 6.7 per cent of its Gross Domestic Product on health, compared to an average of 8.2 per cent in all OECD countries, and 13.5 per cent in the USA. The proportion of the UK's GDP spent on the

NHS fell during the 1980s until the administrative cost of introducing the Conservative health reforms reversed the trend at the end of the decade.

A weakness in Abberley's argument is its failure to link increased spending to improvements in health. Compared with the UK, the United States spends twice as much of its GDP on health but has, in many respects, poorer health—illustrated, for example, by a higher infant mortality rate.

Anna Coote, IPPR's Deputy Director, cautioned against increasing taxation to pay for higher NHS spending for three reasons: there is little evidence that bigger budgets buy better health; raising taxes is electorally unpopular; and it does not avoid the need to take difficult decisions about health priorities: "No matter how big the cake we still have to slice it." There are plausible arguments that money spent on job creation or childcare, for example, may do more to improve health than similar spending in the NHS.

Maynard argued that the NHS, compared with other health care systems, was extremely successful at controlling price inflation. Its provision of high quality health services at relatively low cost was one of its great achievements. Cost containment therefore had always been an NHS objective and should remain one. There are plenty of vested interests (pharmaceutical companies, doctors—he might have said health service unions, but tact restrained him) that want higher spending, but it is the government's job to resist these claims. The NHS, he argued, should eliminate "useless" treatments and rank the rest according to their cost-effectiveness. Without cost containment as a policy objective this would never happen.

### *Health inequality*

The health gaps between rich and poor, between social classes, between north and south, and between the inner city and shire counties have all widened during seventeen years of Conservative rule. The need to allocate NHS resources equitably, so as to reflect differential health needs, was stressed by Kevin Barron, Anna Coote and Alan Maynard. But more money, by itself, does not buy better health, so what else needs to be done to close the health gap?

Professor Andy Haines believed the government's Foresight Programme provided some clues. Information technology has the potential to improve epidemiological research, and to tell patients more about their condition. Genetic research is unravelling the interactions between genes, the environment and polygenetic diseases. This data needs to be applied to the health impact assessments which Labour says will be made by all government policies.

### *Rationing*

Any government that believes in equity, in treating patients according to their health needs, must give priority to those patients whose needs are greatest. And, if the government wants to maximise the collective health status of the population, it must concern itself with cost-effectiveness, and target resources

on those treatments that are most likely to improve health.

The difference between priority setting and rationing is largely semantic, but semantics are important in politics. Rationing is unpopular because people with treatable conditions do not like to be told that they cannot receive treatment, even if the reason is to give priority to other patients with greater needs.

Late last year Berkshire Health Commission was torn apart at a well-attended public meeting for announcing that it would save £3.5 million by rationing twelve treatments. The Commission made two mistakes: it served up its decision as a *fait accompli*—there was no effective consultation, and objections at the public meeting were ignored; and secondly, the commission presented its decision as a ban on doctors carrying out the listed treatments. After the meeting the Commission backtracked, saying doctors would have discretion to use the listed treatments when, in their clinical judgement, they thought they were appropriate, but no-one believed them. The reassurance came too late, and was not matched by a reduction in the cash saving the commission sought to make. Difficult though it is, the issue of rationing cannot be ducked. According to Maynard, the problem was not whether, but how to, ration. Rationing decisions will not be tolerated by the public unless two conditions are met: the public must be involved in the decision, and the criteria for rationing must be explicit and command public approval.

Anna Coote argued for a rights based approach, in which care for certain defined health needs would be a right of citizenship—or residence—in the UK. Since the NHS cannot guarantee to meet every health need, the public (as well as doctors, accountants and the state) should set criteria to define the range of needs which fall within the right to care. These criteria should be equitable, intended to create social solidarity and democratic legitimacy, and to take account of the effectiveness of the therapeutic response to each particular health need. The public could express their views through "citizens' juries", which she describes later in this pamphlet. The eventual consensus would become a national framework for rights to care. Once the framework is established the burden of proof would rest with a health authority, if it chooses to refuse treatment, to show that its rationing decision is consistent with the national framework.

Alan Maynard took a more scientific, but less democratic approach. The NHS should pay only for treatment of proven therapeutic value. The burden of proof should rest with clinicians, using randomised controlled trials or other rigorous scientific methods, to demonstrate that a drug or surgical technique, or other intervention, improved the health of their patients. It is naive to assume that this is always the case: a recent survey of the clinical literature on procedures commonly used in pregnancy and childbirth found that only half had been subjected to clinical trials, and of those that had been tested 40 per cent were found to be beneficial but 60 per cent were either of doubtful value

or positively harmful. Once there is sound scientific evidence that a procedure is beneficial it should be provided by the NHS if it is as, or more, cost effective than competing therapies for the same condition. To pass the cost-effectiveness test a procedure must be either more effective clinically, or as effective as a competing procedure but cheaper.

Maynard's approach is entirely consistent with one of the five priorities in *Renewing the NHS*: "to develop services based on research and evaluation—evidence based medicine—including measuring the success of treatment and not just the speed of treatment." But it might conflict with another: "to extend patient choice through greater information and involvement". What if patients decided they wanted their local NHS to provide an ineffective treatment—cosmetic surgery, for instance? Doctors, managers and politicians ought to point out that the money used for these treatments could be better spent, but at the end of the day the NHS is a public health service and its legitimacy depends on public approval of what it does. An amalgam of Coote's approach with Maynard's seems necessary.

### *Evidence based policy making*

Evidence based medicine is the buzz phrase, but sooner or later the doctors were bound to strike back. Professor Andy Haines called for the same standards of evidence to be applied to policy making as to clinical behaviour. One of the worst, and most costly, features of the Conservative health reforms is that they were dreamed up in a back room in Downing Street and released on the NHS without pilot studies to test how they would work. Nor have they been independently and rigorously evaluated since their introduction. If a Labour government wants to avoid the same mistake it should pilot its changes in selected hospitals and regions.

### *General Practice*

The 'Fundholders or Commissioners' session involved Dr Rod Smith from the Berkshire total purchasing project, whose own practice was a first wave fundholder. He drew attention to the fact that they appeared to be more efficient purchasers than the health authority and had introduced a number of valuable changes in services. Fears of privatisation were unfounded as their experience was that they had reduced their use of the private sector over the years. Dr Ron Singer represented the non-fundholding view and is a leading member of the National Association of Commissioning GPs. He believed that GPs do need to be involved with the commissioning of services, but that this was best done in alliance with the health authority rather than as semi-autonomous fundholders who cost a disproportionate amount in management costs and who are unaccountable. Both speakers reflected a convergence in that the Berkshire project had developed beyond the simple elective surgical contracts based on one practice into total purchasing with a total practice population of 85,000 people

where strategic issues had become important and an alliance with the health authority and other agencies necessary. Similarly Ron Singer accepted that GPs could not just give advice and walk away from the shared responsibilities about difficult resource issues and quality of care. The convergence of these two makes the Labour policy on locality commissioning quite plausible.

### *Long-term care*

Private health insurers have made much of the demographic timebomb—the growing number of elderly people with high health care costs and the decline in the number of people of working age contributing taxes to pay for it. QED: buy private insurance. The vested interest is transparent. Kevin Barron pointed out that ageing is not a new phenomenon: since 1948 the population aged over 70 rose by 75 per cent, but is likely to increase at only half this rate in future.

Melanie Henwood told the conference that the ratio of women aged 50–59 (the age group most likely to be caring for an elderly relative) compared to the number of people aged over 85 was 6:1 in 1981, but fell to only 3:1 in 1991. These unpaid, informal carers, on whom any policy for long-term care in old age depends, are simply running out.

Melanie Henwood wanted Labour to establish a national policy of legal entitlements to community care to replace the present lottery in which the care that dependent people receive depends on where they live. She highlighted the electoral attractions of the policy to the one person in seven in the population who is an informal carer.

### *Accountability*

The NHS suffers from a serious democratic deficit which undermines its legitimacy. The inherent problems of the Morrisonian model have been made worse by the "quangoisation" of NHS regions and hospitals and the removal of elected representatives from most health authorities. Community Health Councils need more power and resources if they are to become effective watchdogs. The conference was evenly divided on whether local authorities should become health purchasers, to enable them to integrate health, social services, housing—and indeed other services like transport and education—or whether they should appoint lay members to independent local NHS authorities.

# 2

## What will Labour do?

Kevin Barron

**I**n a wide-ranging speech Kevin Barron analysed the history of the NHS and the crisis the Tories are driving it towards. His speech focused on the proposals put forward by Labour's health team in *Renewing the NHS*. Here we reprint the section of his speech outlining how Labour would reverse the crisis in the NHS.

Labour will attack unjustifiable health inequalities.

The government has refused to address the problem with fairer economic, education and employment policies, but we will use all the avenues open to us.

We will start by appointing a Minister for Public Health to co-ordinate interdepartmental action to tackle health inequalities and promote good health.

A planned improvement in health, both in the community and at work, is what Labour seeks.

By developing a long-term strategy to lift people out of poverty and to secure opportunities for employment for all, standards of health can be raised in a way which even vast increases in expenditure on healthcare might never achieve.

The strategy and objectives set out in the *Health of the Nation* are inadequate—we will be more focused in our approach but more ambitious in our goals. We will develop targets, based on evidence of benefit to health, which recognise the balance between the responsibilities of government and those of communities, families and individuals.

Childhood asthma is an example. It has doubled since the 1970s. Inclusion of asthma in the *Health of the Nation* would influence our transport and environment policy; promote local awareness campaigns; encourage co-operation between health and local authorities; and generate a shift of attention to primary care.

We will also establish targets associated directly with inequality—such as low birth weight and diseases such as TB. And we will aim to set a framework within which specific targets, wherever possible, could be set locally—local water quality, for example, is one that we'll look at.

And our targets will help encourage health promotion partnerships between health and local authorities, businesses and voluntary groups.

Another problem that Labour must tackle is the provision of General Practitioner services. Labour will improve them.

Substantial variations in the availability of GPs is one area that we will look at. Deprived areas generally have fewer GPs and a lower level of services and



no attempt is made to redress the balance with a fairer funding formula.

GP fundholding has made the situation worse. Preferential treatment for GP fundholders simply adds to the already considerable evidence that there is now a two-tier health service.

Every GP fundholder receives at least £35,000 per year for administration. One estimate is that overall costs are probably running at £80,000 per practice—that's well over £100 million spent on administering the fundholding scheme which could be spent on all patients.

Labour proposes GP commissioning to take the place of the current system. All over the country examples of GP commissioning are already operating. There are more than 60 groups in operation, covering 5,000 GPs and at least 11 million patients. Our plan for GPs is already up and running and working.

Family doctors and health authorities will work in partnership to serve all patients. Different relationships will develop between GPs and health authorities to reflect local needs. Labour will encourage diversity and innovation to meet varied local circumstances.

And the health authority will be unable to ignore the wishes of GPs. We will insist that authorities' commissioning plans genuinely reflect the wishes of local GPs. And we will look to extend the practice that already exists in some areas where the health authority seeks the approval of the commissioning group before health agreements are made with hospitals.

And, under Labour, GPs will be given substantial new powers.

First, all GPs will be able to refer their patients to the hospital or specialist they want.

Second, we are offering all GPs an enhanced role in the planning and public health functions of the health authority.

Third, as GP commissioning is less bureaucratic than fundholding, some of the money saved could be spent on GP commissioning groups. GPs themselves could then be paid for their work in commissioning care.

The providers of healthcare are only a part of the NHS, and Labour will work towards better rights for the users too. We will extend patient choice through greater information and involvement. We will give patients greater representation on NHS boards.

And health authorities and hospital boards will not be stuffed full of party political place-people, but will be openly selected and broadly based to reflect the communities they serve.

Further, we will transform the neglected voice of the patient—the Community Health Councils. We want them to become Local Health Advocates which will be given new powers both to raise standards in hospitals and general practice and to provide more information to patients.

Community Health Councils—and Local Health Councils in Scotland—can be undervalued. I believe that their work is important. At the moment, for example, I am leading for Labour at the Committee Stage of the Bill which will

2  
alter the NHS complaints procedure. And I will be proposing an amendment to give CHCs a statutory role in ensuring the independence of the new complaints procedure.

Labour will also wish to develop services based on research and evaluation, measuring the success of treatment and not just the speed of treatment. And we have already put ourselves at the leading edge of the health debate with evidence-based medicine.

Traditionally, there has been little scientific evidence to support many healthcare interventions. Treatment decisions have been left to clinicians who have drawn on professional knowledge, past experience and practice.

Today, there is a growing movement—not least from clinicians themselves—towards grounding clinical and managerial decision-making more firmly in scientific and systematic reviews of the available evidence on patient care. Labour welcomes that.

And, in order to effectively co-ordinate and plan healthcare provision, we would like to be able to compare the quality and effectiveness of services and treatments. Information on effectiveness and comparisons between hospitals could be powerful tools in leveraging up standards.

But much more research, information and evaluation are needed on which treatments work best and also on the standard of services in different areas. The evidence available for purchasers and providers of healthcare is limited to a small proportion of treatments; it is variable in quality and can be surprisingly difficult to obtain.

The NHS national research and development programme has made the dissemination and implementation of research findings into a priority. But, again, there is still a need to better co-ordinate the provision of information, to improve the ease of access to it, and to offer more and better training and guidance into its use.

Of course, adopting an evidence-based approach is likely to require a huge change in the culture of the NHS.

Many health authorities and trusts have yet to fully understand the potential importance of effectiveness information. As they do, integrating effectiveness data into existing clinical procedures—and adapting purchasing and provision patterns—could have a profound impact on clinical practice.

Labour believes that—if we get the information right—an evidence-based NHS can result in many patients receiving better care.

And it will also lead to a more considered approach to health policy making, because clinical effectiveness information can be used to improve services in a co-operative culture. A culture where a willingness to understand weaknesses and encourage innovation and change would be used to improve patient care.

And I must say one other thing about evidence-based medicine. I believe that its primary aims must be about instilling good practice and providing better and more effective services and care.

3

But it's undoubtedly the case that evidence-based medicine may also have a role in freeing resources to re-direct to patient care. We shouldn't be afraid of this subsidiary role, but we must always remember that it is, if anything, an offshoot.

It is not—and must never be—the primary function of clinical effectiveness information to cut costs. Patient care must always be at the forefront. The rationing of certain types of healthcare that some units are presently undertaking has no part in the evidence-based medicine debate. If a treatment is clinically effective, that is sufficient justification for its retention.

Let me turn, briefly, to some other areas where Labour would like to see improvements.

We will provide a rational and fair framework for services and support for the growing number of elderly people, and we will establish a Royal Commission to report quickly on long-term care.

We want to see the widest public debate on the community services people have a right to expect and how best they should be provided and funded. Our Commission will look at the interfaces between health, housing and social services and the benefit system.

We will want to examine the whole basis for deciding who gets what level of care, and the system of funding that care. And I personally believe that we should look at the role of local authorities in much greater detail.

The burden of provision for long-term care may well be best handled by local authorities coordinating a total care package. The crossover between health and social services in this area is already great and there is a much wider scope for accountability of services under local authority control than presently exists with the current multi-agency approach.

And we will encourage the use of best practice like the Community Care Guarantee concept, where a negotiated agreement of user's needs matched with a package of services means that those needs are met. It is for local authorities to ensure that all care is provided to consistent high standards.

Labour's approach to restoring morale, providing a more efficient service, and improving public health is straightforward. We will embrace a total approach to health care, rather than focusing simply on the NHS.

Our proposed Health Impact Policies will improve co-ordination between services, providing better analysis and developing collective views on priorities.

A dedicated unit within the Department of Health will advise and support ministers on the implications of all government policy for health. It will replace a unit currently promoting privatisation.

Health audits will be built in to all levels of government. Government departments will be obliged to include health impact statements as part of their annual reports to demonstrate the effect of their policies on the health of the nation. We have to commit ourselves to using every means at our disposal to improve the health of the nation.

If, for example, diesel fumes cause asthma, then we act on the cause as well as treating the effects. Treating the symptoms alone will bring a lower success rate than tackling the cause. By requiring each government department to examine the health effects of its proposals, we will be working to tackle the cause.

And it is not just a central government thing. At local level too, we want Health Impact Policies to encourage the sort of inter-departmental and inter-agency working that can be seen in Labour councils like Sheffield.

And we believe local authorities, as democratically elected representatives, should have a duty to promote the overall social and economic well-being of the communities they serve.

A Labour government will work with the profession to revive NHS dentistry and develop a strategy to ensure that the maintenance of oral health is encouraged. We will also aim to tackle the vast differences in oral health in different parts of the country and between different groups of people.

And we will act on health promotion programmes too, ending years of government failure.

Health promotion does not mean suggesting to elderly people that they wear woolly hats in bed in the winter, it demands a clear set of rights and responsibilities for citizens and government alike.

Smoking is the greatest single cause of preventable illness and premature death in the UK—killing over 110,000 people a year. Ill-health from smoking costs this country £750 million a year. Labour in government will work to reduce preventable deaths from smoking and we will ban tobacco advertising. Addressing inequities in screening and treatment of cancer will be a matter of urgency. Rapid detection of cancer and fast, effective treatment carried out by sympathetic well trained staff must be our aim.

We propose to formulate a proper national AIDS strategy: a comprehensive policy to combat the spread of HIV and to support those living with HIV and AIDS.

The Health Education Authority will have a wider public health function and a remit to monitor trends, review research, advise public and independent bodies and disseminate best practice as well as educational material.

# Past and present

# 3

Howard Glennerster

**T**he Labour Party has every right to be proud of its contribution to the creation of the National Health Service. It is probably the most successful social institution to have been created in the past half century. We tend to forget that the health care systems of the 1930s were deeply unpopular, as opinion surveys and evidence to the Beveridge Committee show. Moreover, although the coalition government during the war did have plans for change, they bore little resemblance to the service that emerged under the Labour government. In this sense the NHS was unique. The 1944 Education Act was a coalition measure. The social security reforms owed a lot to Beveridge even if they did not fully implement his recommendations. It was the NHS that was really new and has proved the most robust of all those post-war measures.

Its achievements have been considerable. Infant mortality was running at the level of 60 per 1000 live births in the 1930s. Now it is 6. Similar indicators show the same dramatic improvements. They cannot all be put at the door of the NHS. Improved nutrition and housing have played an important part but so too did the NHS's pre- and post-natal care we have come to take for granted. Having just come back from the United States where my young grandchildren are, it is clear that the richest state in the richest country in the world is still light years behind providing such care and support.

In 1948 mothers and children were given access to GPs in a way denied to most before. Right up until the mid 1980s at least, differences in life expectancy in Britain narrowed across the population and regionally. Differences in the distribution of doctors and health resources narrowed too in response to the measures that the last Labour government took.

In the 1980s many of these achievements faltered, partly because of the sharply growing inequalities in the wider society but also because the Conservatives decided to hold real health spending down well below the rate of growth in the economy and below even the rate of increase in population weighted by age. Whenever this happens waiting lists grow and with them use of the private sector.

Relative to other systems of provision and finance the NHS has proved remarkably cost effective and capable of achieving levels of equal access and life expectancy few other systems can match and all at levels of spending as a percentage of GDP that leave other countries green with envy.

## Complacency

The very success of the NHS and the fact that the Labour Party invented it, or at least acted as midwife, tended to blind the Party to its real and growing deficiencies.

The NHS was created as a creature of its time in the image of the other great centralised monopolies of the day—British Rail and the National Coal Board. It was to be largely run by senior doctors, the balance of power shifting, despite Bevan's wishes, to the hospitals. Lay representatives had virtually no impact.

Inheriting every old bit of machinery and adding many more, the NHS ended up with multiple layers of administration—Regions and Areas and Districts and Health Executive Councils and then Family Health Service Authorities with shadowy Local Medical Committees pulling the strings behind the scenes and all this separated off from social care that is critical for so many elderly and mentally ill people.

Partly to pay off the medical profession and partly because of the mess local government finance was in the 1940s democratic representation was removed to the very top—the Minister or Secretary of State—necessary but not sufficient for democratic accountability. This was quite unlike Sweden that managed to create a very similar service financed out of taxation but run by county councils.

Fabians in the 1930s like Evan Durbin and Hugh Gaitskell had warned against the Morrisonian model of national monopolies for public industry and services. They would lead to provider domination and minimal responsiveness to the consumer, they argued. What they said proved right about other public services and it began to become true of the NHS too, though it took longer for the deficiencies to emerge. Patients had neither voice nor exit power—the power that derives from the capacity to withdraw one's custom.

## *The "reforms"*

The Conservatives' attempt to run the NHS at a level of funding that rose less than even population changes demanded, between 1983 and 1987, provoked a crisis which led to the Cabinet review of the Service. At the outset it is quite clear that Mrs Thatcher wanted to move towards a more privatised form of funding and an insurance basis. It is also clear that various forces, not least the Treasury and her then Chancellor, stopped her. What emerged was a set of changes that were very different and were prompted and crafted by many who were strong supporters of the NHS. What followed was not only not all bad but was what any radical Labour government should have done before had it not been so besotted with the old-style NHS.

First, the changes produced a much clearer set of expectations and contractual rules for GPs and incentives to do more preventive work which previous Labour governments would have liked to do but did not.

Second, the separation of the functions of planning and health needs assess-

ment from the task of managing a hospital or community service has been liberating and is getting that job done, really for the first time. That and the recent rationalisation of the service, amalgamating districts and Family Health Service Authorities and the abolition of separate regions leaves a much simpler structure. Indeed, it looks remarkably like the structure recommended in the Brian Abel-Smith-Crossman green paper of 1970. I can just hear my old boss Dick Crossman's deep chuckle as he surveys Virginia Bottomley's handiwork!

Third, and most important, the reforms have shifted the balance of power away from the vested interests in the medical profession and away from hospitals and towards primary health care. This is partly by introducing some competition—the power to choose different providers on the part of districts and most effectively the power GPs have to get involved in deciding on service provision.

In short, the Conservative reforms have addressed some of the historical legacies and issues any Labour government should be pleased to have seen tackled. The party should stop banging on about how terrible the Tory reforms have been and go on to build on them and take some more steps forward.

## *Funding*

The latest budget sets out an absolutely stable real terms budget for the NHS up to 1999! The Treasury, in its real terms assumption, concludes that prices in the NHS will go up at the same rate as in the rest of the economy. In health this is not the case because wages and salaries make up the main part of the bill. So what the budget actually means is a decline in real spending on the NHS until the end of the century. This is not necessary in economic terms. If the economy is growing by 3% as the Government claims, it means a declining share in the GDP for health. The Government has assumed the public would sacrifice a good health service for a cut in taxes. There is a lot that suggests they do not want that.

The one area where new or different forms of funding might be contemplated is in the area of most pressure—the long-term care of the elderly. A number of ideas have been put forward to revive the service by bringing in more public and private resources. The Germans, for example, have imposed an addition to their social security tax to fund long-term care.

Finally, we need to end the idiotic and damaging division between the health and community social services and the social services departments. Primary care is the natural place to locate care management and community health services. Here the reforms have not helped. A single statutory agency responsible for mental health, with social and medical responsibilities clearly assigned to it, is something which needs to be looked at. We do not want any more big bang solutions to anything without careful appraisal. But there are some radical ideas to pursue. That is what New Labour should be doing, not fighting outdated battles.

## 4

# Is there a crisis in health care?

Anna Coote

**T**he debate about health services seems to be lurching towards a pre-determined solution—one which directly conflicts with the idea that all citizens should have equal rights and opportunities, and equal life chances. The story goes that there is a crisis in health care and the only solution is to cut back services currently available to all, increasing the amount paid for privately. Demand for health services will grow, so it is said, at a dramatic rate, throughout the Western World. Demand driven by an ageing population, by expensive new treatments, by changing public attitudes—towards a more assertive consumerism.

Apocalyptic scenarios of this kind take no account of the fact that patterns of demand can change. For example, some new treatments may reduce demand for other more expensive ones. The public may be getting pushier, but it is also growing more sceptical about what medical science can achieve; people are less likely to have blind faith in doctors. More are using self-help groups rather than GP surgeries to deal with chronic illness. There is some evidence that morbidity is being compressed, so that a longer life does not imply greater need for health care.

And on the supply side, health services may find ways of increasing provision within existing resources, for example, by cutting back on unnecessary internal accounting, or by cutting out ineffective treatments.

The point is that patterns of demand and supply are less certain than many have suggested. There may be a crisis or not; we don't know for sure how serious it will be. But by the same token, we must be prepared for an unpredictable future, and for choices that will have to be made in any event.

The perceived crisis in the UK has been brought on by a new openness. Since the birth of the NHS, doctors have had to decide whether it is worth treating this patient or that, or giving this treatment or that. Costs as well as clinical possibilities have influenced their decisions in the past, just as they do now. The NHS reforms shifted some of the burden of decision-making from doctors to managers and made the whole thing more transparent. And meanwhile the flow of public funds to the NHS has been squeezed by a government keen to cut taxes. The fact that people are newly worried about rationing does not mean that rationing is new. But it is not being done more openly, by different people,



or more intensively than in the past.

As part of this pattern, access to health services have become a geographic lottery. Different Health Authorities are making different judgements about how they are going to manage scarce resources. What you get depends on where you live. This feeds a sense of injustice and insecurity.

Public confidence in the NHS is ebbing away. People no longer believe that paying taxes and national insurance for a working lifetime will guarantee them the healthcare they need when they need it. They certainly don't trust this government to safeguard the NHS in the public interest.

One consequence is that those who can afford it are, increasingly, tempted to go private. They buy the right to jump queues, to get treatments that might otherwise be denied them. This not only creates a two-tier service with better services for the better off. It breaks the bonds of common interest that bind us together. It begins to destroy that sense of a shared investment in services that we all own and all need. This is the route to social fragmentation and injustice, to conflict, to a thinning and fraying of the fabric of democracy.

Our aim is to find ways of restoring public confidence and reuniting all sectors of society as owners and users of the national health service. We cannot accept the status quo. Yet we recognise that the money we have to spend on health is not infinitely elastic. So what are the options for policy-makers?

One option is to muddle through and hope that, one way or another, doctors and managers will be able to get by with a minimum of public embarrassment. The main motive for muddling through is a fear that anything more purposeful is bound to be worse. There is certainly a fear of more public debate—on the grounds that the public are incompetent and can't be trusted to participate in delicate decisions of this kind. However, muddling through is not an option—because of the inconsistent, unfair and undemocratic basis of decision-making at present. Decisions about managing public resources in the public interest are political not technical matters, and the public should have a say in them. It will lead to better informed decisions and help to build a stronger public consensus about what the NHS is for and the way it works.

Another option is to raise taxes, so that the NHS can do more to meet growing demand. It is often pointed out that the UK spends a lower proportion of GDP on health care than most OECD countries. Why not spend more, and bring us up the league tables? The trouble with this idea is that no matter how big the cake is, we still have to decide how to slice it. There is no reliable evidence that when it comes to an election, the public will vote for a party committed to raising taxes. Nor is there much evidence that more spending on health care improves the health of the population. If we want to raise taxes in the interests of health gain, then we should spend that money on child care, education, housing, training, jobs ... all have a stronger claim than health services to be good for the nation's health.

A third option is to define a basic health-care package, with lists of what is

4  
in or what is out. A package could be universally applied, so as to rid us of the geographic lottery. People would know where they stood. But this is a crude and reductionist approach which is bound to cause injustices and distort clinical judgement. It will hasten the departure of better-off citizens from the national health service to the private sector.

A fourth option is to take a positive, rather than a negative approach and develop a rights-based health care system. So that health care becomes a right of citizenship, rather than a matter of privilege or luck. But instead of going for substantive rights to particular treatments, it is preferable to define rights to health in generic terms and to concentrate on process.

In order to define, we have to be clear about our aims and values. Without elaborating, let me sum up what I think these are:

- Appropriate health care: effective and efficient treatment.
- Equity: no unfair discrimination. Everyone should have an equal chance to enjoy health care which is appropriate to their needs.
- Social solidarity, which is about recognising that the promotion of good health for all and the treatment of ill-health for all, require a collective approach. We must aim to build and maintain a sense that we are all in this together.
- Democratic legitimacy: key decisions about the NHS, its shape, its purpose and how it is run, must earn the support of the public, through the democratic process. We live in a democracy, this is our health service.

The starting point for a rights-based approach is to develop a national framework, based on a democratic consensus about what the National Health Service is for, how decisions are made and by whom. So that decisions can be seen to be consistent and fair across the country. Within this national framework, we want clear guidelines drawn up for local health authorities to follow. These guidelines would not dictate which treatments are available or which ones are ruled out. They would structure the way in which decisions are made. Doctors and managers at a local level would abide by a shared set of criteria and procedures.

Affordability would not be the overriding criteria, but one among others no less important. For example, is this particular intervention necessary and appropriate? Is it considered effective? Do the potential benefits outweigh the dangers? Have the views of the patient and the patient's family been taken into account? Have agreed procedures been followed? A Code of Practice along these lines would end the geographic lottery and begin to restore public confidence in the service.

Once the Code of Practice is in place, individuals should have a *prima facie* right to receive treatment appropriate to meet their needs. If treatment is

refused, the burden of proof would be on the health authorities to defend their decision, rather than on the patient. Only certain categories of defence would be acceptable—one being that the Code of Practice had been followed.

As part of the National Framework, there should be clear and enforceable procedural rights for patients and would-be patients. The principles of judicial fairness would be applied, consistently to the administration of health services. Rights to information, to be heard, to unbiased decision-making, to equal and consistent treatment, rights to be given reasons for decisions, and rights of appeal and complaint.

These are highly significant changes. At present individuals have no enforceable rights to health care. There is a duty on authorities to provide health care, but case after case has demonstrated the incapacity of the law to enforce treatment claimed by individuals. The Patients's Charter sets out a list of so-called "rights" but these are not enforceable—all patients can do if they don't get them is complain after the event.

We propose a National Health Commission, whose job it will be to develop a national framework and a code of practice. The Commission will pool expertise and attempt to build a consensus about criteria and procedures for planning and resourcing health care. We also propose that citizens' juries are used to provide an input from the public to the Commission's deliberations.

To sum up, the key components of a rights-based approach are: a national framework, a clear set of guidelines, a new citizen's right to appropriate health care, and new rights to fair treatment (not just treatment in the clinical sense, but all a person's dealings with those who administer health services). It is better than muddling through. It would be more popular and politically feasible than raising taxes. It is more flexible and more positive than a basic package. New mechanisms are required to take key decisions: a National Health Commission with input from the public via citizens' juries.

These ideas are currently being developed by the IPPR. Our report will be published later this year.

# 5 GPs – Fundholders or commissioners?

Two doctors in the field debate the merits of different systems

Dr Rod Smith

**T**he debate between fundholders and commissioners implies that fundholding and commissioning are radically different and cannot co-exist as equally valid ways of providing patient services. My own view is that the idealism that drives most GPs can equally well be expressed through fundholding or commissioning, and the important issue is that all GPs should be involved in commissioning in some way, whether it be fundholding or commissioning. As a total fundholding practice involved with 5 other practices and 86,000 patients (about 10% of Berkshire's population) I see little difference between total fundholding and successful commission-led locality purchasing. In both the key factor for success is the active involvement of all GPs. Politics, with both a large and a small P, has for too long got in the way of rational debate about the merits of fundholding as one of a variety of possible approaches to commissioning.

## *What is fundholding?*

Fundholding is merely one form of commissioning and uses the modern management technique of devolving resource consumption decisions to the lowest practical level within an organisation. GPs by their actions consume much of the resources of the NHS. By giving them responsibility hopefully they can make more appropriate judgements about resource usage than remote central planners, who rarely see patients and probably have a less sophisticated awareness of deficiencies in local services than GPs.

Fundholders have 3 funds, staff and drug budgets, set in the same way as for non-fundholding GPs and a hospital and community service budget covering about 20% of patient services. The other 80% continue to be purchased by Health Commissions, as do all services for non-fundholding GPs.

Fundholding GPs receive a management allowance, weighted for their list

size and currently about £49,000 for 12500 patients and computer grants. To these costs need to be added transaction costs with hospitals.

The description above covers standard fundholding. Since April 1995 there have also been options for GPs to enter a lower level community fundholding with list size of over 3000 patients required, and total fundholding usually involving several practices to reduce the risks inherent in purchasing all services. There are now over 50 total fundholding pilots involving over 2.25 million patients and a further 20 will be selected for 1996-7.

### *Fundholding in action*

Fundholding requires considerable effort to realise its full potential. Good information is the key to the successful transition from standard general practice with its focus on the individual patient to fundholding with its more targeted population focus. In my own practice we have been able to achieve many efficiency savings by doing more ourselves, by referral between partners, obtaining more equipment to do more in the practice and referring to other GPs, where we don't possess sufficient skills in the practice eg for vasectomies. Moving work and resources from teaching hospitals in Oxford and London, where historically more resources were concentrated, has helped our local District General Hospital to increase its number of consultants. The efficiency savings released have enabled us to dramatically shorten waiting lists from 2 years for hysterectomies and 18 months for hip replacements and cataracts to 3 months for most procedures and a maximum 6 months.

### *Improving community services*

Because we have cleared waiting lists using efficiency savings we have been able to improve many community services some of which were so badly provided prior to the NHS reforms that patients were forced into the private sector, e.g. physiotherapy. Some of these improvements generate further efficiency savings. Our psychiatric referrals have halved since we provided good psychology and counselling services in the practice.

GPs can identify and react very quickly to changing needs: e.g. a whole new road was built for problem families from Reading by a housing corporation in our practice area and we were able to very rapidly identify the need for and the efficiency savings to resource an extra half-time health visitor. Our practice population is elderly so we have funded a half-time occupational therapy post from the community Trust to shorten 10 month waits for a Social Services Occupational Therapist.

### *The two-tier problem*

Sadly these gains have not been achieved by our Health Commissions, who have failed to create incentives for their GPs to generate similar efficiency savings. Their waiting lists remain unacceptably long and they have made little im-

5  
provement to community services.

The questions arise: are fundholding patients gaining at other patients' expense; have we created a two-tier service; and have we destroyed central planning in the NHS?

### *Effects on central planning and two tiers of fundholding*

Prior to fundholding, Oxford consultants dominated central planning and this was reflected in the results. Each orthopaedic surgeon in Reading looked after 113,00 patients compared with 36,000 patients in Oxford and 38,000 in Milton Keynes. How anyone working in the NHS prior to the reforms can claim this was a one-tier NHS defies belief.

### *How can fundholders improve services for their own patients without damaging services to other patients?*

Correcting the historic two-tier service in Reading was a high priority for West Berkshire Fundholders. By bringing money historically spent in Oxford on our behalf back to Reading we have helped the Royal Berks Hospital increase its number of orthopaedic consultants from 4 to 7 and have given savings and contracts to the Ophthalmology Department to fund a fifth consultant.

Fundholders have been pressing the case for an increased provision of neurology consultants, from half a consultant for a 450,000 population, to deal with waiting times of 8 months to out-patient appointment. The Health Commission has not supported our case, partly because it is overspent, and the Trust has agreed only recently to appoint a second consultant for standard and total fundholding patients only. Whilst it is sad that non-fundholding patients will not fully benefit from this initiative, in practice they should benefit indirectly from relief of pressure on the first consultant's time. Purity might decree that the Trust should continue to provide an unacceptable service for all patients, but fortunately common sense has prevailed.

### *Is fundholding too expensive?*

A justifiable criticism of fundholding is that it is expensive. In my own practice of 129,000 patients we estimate that it costs about £100,000 per annum or £8 per patient to run fundholding if management costs, transaction costs with providers, support costs with Commission and NHSE are included. However against this we receive £17 per patient less for drugs, our total fund with 10% of Berkshire's population is heading for £6 a patient underspend compared with the £5 per patient overspend of the other 90% of Berkshire's population whose healthcare is purchased by Berkshire Health Commission. An investment of £8 per patient in practice management costs to release at least £28 per patient in

cost terms and greatly improved services is surely justified.

Strategic development and good healthcare is impossible in an overspending environment. GP involvement, commitment and ownership is crucial in creating the efficiency savings necessary to control expenditure.

Good information is crucial to drive change and enable good specific contracting. My Health Commission pays half a million pounds for an ill-defined family planning service, which allows the local NHS Trust to tell me that they have no appointments for NHS terminations, so would I mind using the private sector and writes to me in November 1995 telling me to reduce my termination referrals as there will be fewer appointments over Christmas. As a Total fundholder I will ensure that terminations are provided as needed and payments will be withheld if they are not. My own view is that one of the reasons that fundholders have been more successful than many, but not all Commissioning groups, is that the management allowance has encouraged the collection of good data and I would argue that most Commissioning groups are grossly underfunded and thus prevented from performing successfully. Management allowances should be made available for GPs.

### *Do fundholders cherry pick?*

One theoretical worry about fundholding is that GPs would cherry pick, keeping low cost patients and discouraging high cost patients from coming onto their lists. Practically it is difficult to see how GPs could identify expensive patients and discourage them from coming onto lists. Many fundholders dislike the two tier system that has arisen and theoretically it could lead to reverse cherry picking—a wise patient needing a hip replacement might limp round to join a fundholders list. In practice there is little evidence of cherry picking, despite enthusiastic searches for it by opponents of fundholding.

### *Fundholding savings*

The issue of savings has been highly contentious within fundholding. Critics claim that savings are diverted into GPs' pockets because they can then spend them on premises which the GPs subsequently own and that the money would be better spent on extra operations. Fundholders counter that savings are difficult to make (if they were easy Commissions would make them too), premises need to be improved to house new services and savings spent on new premises are little different from improvement grants or cost rent schemes, the grants available to all GPs to improve premises. The first question about savings is whether they arise due to overfunding. The complexities of budget setting and what is in and out of standard fundholding make this question difficult to answer for standard fundholders. There is conflicting evidence on whether fundholders have fair budgets, with North West Thames almost certainly overfunding fundholders in the early years and other Regions underfunding them. Evidence will be much easier to amass in total fundholding and

as I have shown earlier our own evidence from Berkshire is that total fundholders consume less resources than other GPs.

In considering alternatives to the use of savings for GP premises NHS administrators will need to be mindful of the history of health centres, state owned buildings, which cost more to build and which in Berkshire at least no longer exist as the FHSA encouraged GPs to purchase them themselves, because they were so badly cared for.

### *Are fundholders privatising the NHS?*

A recent BMJ paper comparing first wave fundholders in the Oxford Region with controls between 1990 and 1994 showed that referrals to the private sector fell by 8.8% amongst the first wave fundholding practices, including my own, whilst referrals to the private sector rose by 12.2% in controls. This was a surprise to the researchers but not to the GPs who know that patients respond to poor NHS services by using the private sector and had entered fundholding to improve patient services.

### *Challenges for a Labour government*

I have tried in this paper to demonstrate that fundholders are a committed group of NHS commissioners. Having heard some of the more successful GP non-fundholding commissioners speak I personally see little difference between commissioning and fundholding GPs. My own practice's involvement in a total fundholding project involving 6 practices and 86,000 patients provides a model for locality purchasing in Berkshire. The challenge for Labour will be to retain the enthusiasm and commitment of fundholding GPs, who may find committee work less enticing than the real and dramatic changes they have effected through fundholding. Many fundholders agree with the Nottingham fundholder's quote that " 1 GP with a chequebook is worth 10 on a committee."

Most fundholders are committed to equity of funding rather than performance. Poorly performing Health Commissions must be helped to catch up with their fundholders if that is possible or replaced if not.

Fundholders have proven much better than General Managers at controlling consultants, most of whom like GPs are committed to a high quality NHS, but a few of whom ran personal fiefdoms uncontrolled by anyone, prior to the onset of NHS Trusts.

Morale in General Practice is generally low, although probably higher in fundholding practices as they have been able to ensure that some resources accompany the inexorable work shifts into primary care.

The greatest challenge will be to ensure that the substantial number of GPs not involved in fundholding or commissioning become involved.



## Dr Ron Singer

We do have to do something about fundholding and incorporate it into a wider and less divisive concept of GP involvement in the commissioning process. Fundholding alone is not enough because, even with 50% of GPs in such a scheme, the health authority still has to directly purchase the majority of health care.

Also, many GPs have found a different route into the commissioning process by setting up commission groups.

Fundholding does have its problems. It has led to "two tierism" – it brings health services faster to its own patients; and faster for some means slower for others. A two-tier service reflects the way fundholding was designed.

Fundholder 'savings' is a travesty. In no other sphere of government finance is an underspend called "savings" and in no other situation can the budget holder keep these "savings". While millions of pounds of fundholders' unspent "savings" are lying around in FHSA bank accounts, patients in my practice have to wait for specialist attention. Meanwhile, any fundholder who overspends is bailed out with money that would otherwise have gone to my patients.

So what is GP commissioning and how does it differ from fundholding?

A very neutral, fair and charitable characterisation of fundholding might be:

A product of the right which aims to decentralise health service spending, place the rationing of health care at the GP's desk rather than at the politician's and is a short step away from fully privatised primary care. It is fragmentary, destabilising of providers, frustrates health care planning and inhibits team working by swapping the unbridled power of consultants for the unbridled power of GPs. Last, fundholding is purely a purchasing set up. Fundholders plan and purchase only for their patients, often in isolation from their colleagues.

GP commissioning could be characterised as:

A way of involving all GPs in an area, their practice and primary care teams, in a joint venture to assess and meet the health care needs of their population. GP commissioners help their health authority to plan services for all patients, including those not even registered with GPs. It is an inclusive model—instead of some patients, some practices and some services, Commissioning Groups take the wider, area view and include all patients, practices and services.

The commissioning concept represents far more than the simple purchasing of hips and hernias.

At its best, commissioning analyses an issue and explores all available, local resources that could tackle it. Commissioning Groups are a natural way for health care workers (not just GPs) to cooperate and research local issues, design strategies and programmes to meet those problems. This process can range

across health and social services, education, environmental health, the police, roads and housing design. As well as straight forward purchasing it includes assessing the need for health (and social) care, planning the best way to tackle that need, and trying to measure quality and outcomes. It is a positive concept: not anti-fundholding, not non-fundholding, but GP (or indeed Community Nurse) commissioning.

Commission groups are large enough to aid the strategic planning of services but flexible enough to reflect differing local needs because they are based on small practice groupings. It is a model that addresses public health issues (such as inequalities in health)—something that fundholding was not designed to do and cannot be adapted to do.

When Alan Birchall, a member of Nottingham Non Fundholders, wrote a letter to the BMJ in 1992 asking for other commissioning groups to contact him, he received 40 replies. GPs up and down the country had already formed groups and many, like my own group, included fundholders from the outset. The theory of GP Commissioning is already being developed, virtually unaided, across the country, with some of the best practices in the country—so-called first wave non-fundholders.

There are now over 100 groups. The National Association of Commissioning GPs has information on over 71 of these, covering 14.3m patients (1/4 of the population) and incorporating over 7,700 GPs. They receive no government funding, but are quietly achieving many gains and finally national recognition in Labour's Health Policy for their efforts.

Those in favour of fundholding argue that it has proved its worth and that commissioning cannot work as it does not actually control a budget. I believe there are four main arguments against this.

First, evaluation of fundholding is incomplete. For instance, the latest research on fundholders' drugs' budget shows that the early cost saving have not been sustained.

Second, evaluations have never been made (or indeed allowed) comparing fundholding with the work of commissioning groups.

Third, no commissioning group receives direct government funding. The NACGP survey of all groups showed that the most any received was £73,000. the same as would have been paid to 2 fundholding practices. And this is a group representing 500,000 people and 267 GPs!

Yet the money is there. If the total paid out in management fees alone to fundholders were to be split between commissioning groups in each health authority, each group would receive half a million pounds.

Fourth, there are now many examples of the work of commissioning groups. From the reorganisation of mental health services in Bristol, infertility services in Enfield and Haringey, to generic prescribing in Nottingham.

Next year the group which I chair will review, with the health authority, neurology, orthopaedics and urology services. We also hope to look at out of

hours cover from a commissioning point of view. Instead of just looking at the GP side, we will include the 3 local A&Es, the role of GPs and Nurse Practitioners working in them, and develop a mini-Emergency Bed Service for the area.

So, we are beginning to learn what commissioning groups can achieve with little or no money and can only guess at what could be achieved if they were supported as fundholding has been.

I remain convinced that fundholding, poorly evaluated and unloved even by many fundholders, is a highly politicised scheme, whose aim is to cash limit general practice and off load the government's responsibilities for providing adequate health services. It has failed to convince more than half of the Country's GPs after 6 years of bribes and, in some areas, even threats. Of the 50% who are fundholders, polls reveal 66% are "reluctant fundholders", while 70% would welcome commissioning.

Now there is something else on offer that has arisen from within the heart of the NHS itself, born of the old fashioned service ethos that drew most of us into the health service in the first place. (Although this is a very non-New Labour view, I have to say in my experience, it is a view supported by the many GPs and other health service workers).

Patients, GP commissioners, including fundholders, primary care team colleagues, managers and, dare I say, politicians have much to gain from the concept of GP commissioning, which is driven by the planning and delivery of health care—the very concepts that make the NHS such an envied, cost-effective and truly national service.

# 6

## The future of long - term care

Melanie Henwood

**W**hether or not there is a 'crisis' in health care in Britain is a recurrent, and unresolved, debate. The need to balance finite resources against rising demands and expectations; the increasing needs of an ageing population, and the pressures from technological advances are central challenges in all modern health services. Since the reforms to the NHS in the late 1980s, a further element has been added. That is, whether the particular organisation and delivery of health care via the internal market of the NHS is helping or hindering the equitable management of both needs and resources.

Alongside any such debate about the health service, it is essential that consideration is also given to community (or 'social') care, and in particular to long-term care. It is arguable that the boundary between health and social care has become increasingly fluid, and has brought about a redefinition of health needs as social care needs, with a consequential shift from a universal and free service, to a selective and means-tested one. Many commentators have pointed to the withdrawal of the NHS from providing long-term care (or 'continuing care') and the parallel growth of residential and nursing home places in the independent sector as the most obvious symptom of this. As the House of Commons Health Committee has confirmed, between 1976 and 1994 "the number of NHS beds specifically designated for elderly people fell from 55,600 to 37,500, a 33 per cent reduction."

The growth in both the numbers and proportions of elderly people in the population is a distinguishing feature of all advanced societies, and one which has been evident since the mid-nineteenth century. However, the rapid growth in the elderly population, and particularly in the population aged over 75, and over 85, is a uniquely twentieth-century phenomenon.

While it is misleading to infer that ageing and dependency are synonymous, nonetheless there are clear associations between advancing years and reducing capacity, and these are especially clear among the very elderly.

Alongside these changes in demography are parallel social changes, particularly in the nature of the family. Contrary to popular belief, the family continues to play a major role in caring for frail elderly and other relatives. There are an estimated 6.8 million carers in Britain (one adult in seven), the majority of whom are caring for elderly relatives. However, the family is changing. In many ways it is less stable than in the past, with one in three marriages ending in

divorce. Together with other changes—such as in the nature of women's employment—these trends raise questions about the continued capacity of the family to care. It cannot be assumed that families will be willing or able to meet the caring demands of this and future decades (or to do so without substantially more support). This raises major questions for social policy which continues to place the caring role of the family as the central plank of community care.

There will always be a minority of people whose needs for care are so great, or so continuous, that they can best be met in a residential or nursing home environment. Who will pay for this care? Since the late 1980s this has emerged as an increasingly urgent question, and one which is of major concern to ordinary citizens.

Increasingly, the loss (or feared loss) of the family home to pay for care in later life has become a major concern of the public. There has been intense media coverage of these issues which has highlighted the sense of loss and betrayal of elderly people who believed that they had 'paid their stamp' all their lives, and now find themselves left with nothing.

The issue confronting any government is two-fold. How to address paying for the long-term care needs of the current generation (and those likely to need care in the short-term future), and—more fundamentally—how to address this for future generations. Both are necessary, and while some of the issues are similar, the solutions may not be readily compatible. Current policy response has so far been limited largely to reacting to the immediate concerns.

In November 1995 various changes were contained in the Chancellor's budget which were directed at "people who have worked and saved all their lives." In particular, the proposals were clearly directed at people who believe they are being taxed for thrift, and penalised—in particular—for being owner occupiers. At present, people only qualify for all the costs of their residential or nursing home care to be met when their assets are worth less than £3,000, and receive no financial help at all until their assets have dropped to £8,000. The Chancellor observed that "those limits are far too low." From April 1996, the lower threshold will more than treble to £10,000, and the upper threshold will double to £16,000. Kenneth Clarke concluded:

"That means that people in residential care who have worked hard and saved will now keep more of their own money. It will give many elderly people and their families more financial security and peace of mind."

The proposals were widely welcomed, particularly by groups such as Age Concern. Certainly, the changes are an important first step which will address many of the pressing concerns of elderly owner occupiers. People entering residential or nursing homes after April 1996 will spend down their assets more slowly, and will be left holding onto a larger nest-egg than has been previously possible. For those without capital assets and with modest savings the effect will be to lift them out of means-testing altogether.

The need to address the concerns of owner occupiers no doubt had a

particular resonance for the Conservative government in general, and for John Major in particular. The 1992 Conservative Manifesto stated:

"The opportunity to own a home and pass it on is one of the most important rights an individual has in a free society. Conservatives have extended that right. It lies at the heart of our philosophy. We want to see wealth and security being passed down from generation to generation."

John Major has himself addressed the Party Conference on this matter and promised that home ownership is to be the mechanism for wealth 'cascading through the generations'. It has not proved to be so. There has not been the marked increase in the transfer of capital assets at death which economists had widely predicted would be the case on the basis of rising home ownership rates. Instead, an estimated 30-40,000 properties are being sold each year to meet care costs.

While the changes to capital limits will ease the situation, they will not resolve the underlying question of where responsibility for paying for care should reside. These same questions will confront any future Labour government. The issue is also closely tied in to the state of the economy more generally. The boom and bust pattern of the 1980s which saw the collapse of the property market and the avalanche of negative equity concerns particularly among younger home owners, also terminated the 'trading down' opportunities of many older owner occupiers who lost the chance to realise sufficient assets to ensure their own welfare while also protecting a carefully nurtured inheritance for their families.

The Chancellor also announced other measures to address questions of long-term care funding. Consultation is to take place, but full details have yet to be announced. However, in essence the proposals will "encourage people to make provision for long-term care." A joint letter issued by Stephen Dorrell and Peter Lilley on the day of the budget shed further light on the way forward by drawing comparisons with private pensions:

"One of this country's major successes has been encouraging more private pension provision than any other European country. The challenge facing us is to be equally successful in enabling people to make decent provision for long term care, without adding to the tax burden."

If the government's solution to the long-term care challenge is to be privately led, and primarily a matter for individual responsibility, what alternative does Labour have to offer?

To-date Labour has committed itself only to a Royal Commission on long-term care which would "encourage the widest public debate on the community services people have a right to expect and how best they should be provided and funded." Such a debate is certainly needed, since much change has taken place by stealth. However, more than this is required. In particular, there needs to be a restatement of the principles on which any future policy is to be grounded. Such principles as universalism, equity, collective responsibility and the social

contract have long been absent from the policy agenda.

Whatever approaches might be taken to encouraging individuals to assume responsibility for long-term care, it is apparent that this can offer only a partial solution. The private long-term care insurance industry in Britain is of fledgling development. Despite the expansion since the late 1980s in the number of schemes on the market, take-up has been very slow. The scope of existing and emerging financial products is likely to be limited to middle and upper income groups. Based solely on individuals' capacity to pay, any further development of private insurance will compound existing inequalities without resolving underlying problems in the funding of long term care.

For future generations of elderly people (today's young adults and the middle aged) the notion of making private arrangements for care insurance may be more readily accepted. However, left to the private market, the way ahead would not be problem free, and the parallels with the pensions industry provide salutary experience. There have been casualties of private pensions. Most obviously those people with insufficient means or motivation to invest in private schemes have fared badly, while others have suffered from poor financial advice and investment of pension funds. A similar fate could await private care insurance. Moreover, the private insurance market may be inherently unsuitable for addressing long-term care for two main reasons. First, because the commercial insurance market necessarily practices adverse selection (excluding or out-pricing high risk clients), and second because the likelihood of needing long-term care appears sufficiently remote from low risk young people that it is unlikely to be an attractive investment.

Should social insurance address long-term care needs? Despite the conclusion of the Commission on Social Justice that "long-term care in old age is a sufficiently predictable risk to suggest that responsibility should start with individuals", many others would conclude that any 'new model Beveridge' should recognise such risk as a collective rather than individual responsibility.

The changes announced by the Chancellor in the November 1995 budget go some way towards reducing the immediate impact of means-testing, and hence reducing inequities and penalties on thrift and self-reliance. To go further than this in moving away from a means-tested system would require a shift towards a system based more on social insurance, or on partial social insurance.

The changes made to date have been a short-term and incremental response to an issue which requires comprehensive and fundamental reform. The House of Commons Health Committee has now turned its attention to the funding of long-term care, and the Joseph Rowntree Foundation's own inquiry into long-term care is continuing. Such scrutiny is to be welcomed, and could make the task of Labour's intended Royal Commission not only easier and faster, but more focused. The questions which need to be asked are increasingly clear, and must now be answered. The challenge of long-term care can no longer be a matter for short-term political solutions.

## Health Crisis - What Crisis ?

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Is there a crisis in the NHS? Have the Conservatives' reforms made it worse or better? What will Labour do in Government?

Reflecting the contributions and the conclusions of the Fabian / SHA New Year Conference, this pamphlet gives a basis for anyone wanting to understand the current issues in the Health sector:

- Kevin Barron argues the case for Labour's Health Policy outlined in *Renewing the NHS*;
- Howard Glennerster argues that the Conservatives' reforms are 'What any radical Labour government should have done before, had it not been so besotted with the old-style NHS' and that Labour policy should build on them;
- Anna Coote argues for a rights based solution to the crisis in the NHS and a new National Health Commission to help avert it;
- Dr Rod Smith and Dr Ron Singer battle it out over GP fundholding. Dr Smith argues that 'Fundholding is merely one form of commissioning' while Dr Singer finds it is 'a short step away from fully privatised primary care';
- Finally, Melanie Henwood argues that any policy should be based on universalism, equity, collective responsibility and the social contract.

The Fabian Society brings together those who wish to relate democratic socialism to practical plans for building a better society in a changing world. It is affiliated to the Labour Party, and anyone who is eligible for membership of the Labour Party can join; others may become associate members. For details of Fabian membership, publications and activities, write to: Simon Crine, General Secretary, Fabian Society, 11 Dartmouth St, London SW1H 9BN.

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