

NEWSTATESMAN



The future direction of the NHS



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Sixty years ago, few could have predicted that the National Health Service would look as it does now. Indeed, its founders even predicted falling demand for its services, as major infections were brought under control (see page eight).

Predicting what the NHS will start to look like over the next 60 years may be even more difficult as the pace of change will be furious and could lead us in directions that we have not even countenanced.

This supplement, sponsored jointly by the *New Statesman* and Pfizer, invited participants to offer their own expectations for the future direction of health services. What those who have participated in this project seem to agree on is that technology will have a radical effect on the landscape, that patients will be at the centre of their own healthcare and that services will be delivered more locally, even in patients' own homes.

Unabridged versions of all the articles that follow are available on: www.policyforum.co.uk, as are answers to all the questions that were submitted to the panel for the debate (see page 15). Your comments are welcome.

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The great survivor: another 60 years

Liam Donaldson looks to the horizon and considers some of the issues that may arise for health services in the decades to come

The founding fathers of the National Health Service (NHS), calling to mind the decline in major infectious diseases, foresaw a future for the NHS where it would be concerned primarily with the maintenance of health. They even predicted falling demand for its services.

Current predictions about the challenges for the NHS in the short and medium term point to the “usual suspects”: an ageing population, advances in medical technology, growing consumer expectations and burgeoning pools of chronic disease.

It is difficult to contradict the assumption that, a decade from now, the NHS will face more of the same. Need and demand for healthcare will continue to grow, particularly among an elderly population where many individuals no longer suffer from one disease but several: so-called “co-morbidity”. A woman in her late 70s who has had a minor stroke

Above: Aneurin Bevan, minister of health, meets a patient at Papworth Village Hospital in 1948. This centre for tubercular cases was taken over by the NHS the following July

but also suffers from diabetes, arthritis and heart disease is not an unusual patient. However, she would have been when the NHS was founded.

The care needs of millions, often compounded by absent family support, will turn on coordination of care and long-term support to maximise independence. Add to this the ethical and anti-ageism point that new drugs and other treatments should not be denied to older people and the inexorable rise in the volume and complexity of NHS workload will continue unabated.

In response, the NHS, a decade ahead, will surely have shifted its organisational structures and processes towards integration of primary, hospital, community and social elements. Currently, they are too compartmentalised and patients move across care boundaries like ships in a storm. Many of

the structures of the NHS were designed to provide reliable, comprehensive care for people with health emergencies and one-off illnesses. New models of patient-centred care will engage expert patients in the long-term management of their own health, with clinicians there to advise, guide and support their choices. These services will need to be planned and designed in a way that has never been done before.

The consumerist nature of an increasingly demanding society of baby boomers, generations X and Y and their successors will require a significant shift from the stoic “make do and mend” of the wartime generations. While there are differences between the roles of patient and customer, these boundaries will blur. Advanced internet systems will enable patients to consult with expert doctors across the world. Pressure to go with the digital, rather than traditional, referral channels will be enormous. The NHS will have adapted to this, incorporating a new notion of customer service into its ethos and functioning.

A future service must be free from the geographical variations in quality of care that are too common now. The new focus on quality that has emerged from Lord Darzi’s NHS review will have driven the service towards a radical reinvention, where decisions are made to enhance quality rather than minimise cost. Quality will be the currency of the NHS a decade from now.

Over the horizon, into 2030 and beyond, new medical frontiers will have opened up. Today’s young Turks of medical research will be stroking their grey beards with satisfaction as science and technology bring untold benefits to the bedside. Stem cells will repair damaged, diseased and ageing organs and tissues; gene therapy will cure inherited diseases such as cystic fibrosis and muscular dystrophy. Techniques that can control the immune system will switch off autoimmune disease; drugs and cell manipulation will suppress many forms of cancer; and robots will allow surgeons to perform intricate operations on the beating heart.

Three decades from now, it will be routine for babies to have their genetic profile stored on a microchip for life. Faulty genes will be corrected. However, only a proportion of disease is genetically determined and, with the growth of new therapeutic opportunities, most of us will be patients. Advances in diagnostic equipment and scanners, their miniaturisation and intelligent features will move them out of hospital and into the hands of patients.

The impact of these changes will be profound: patients and families diagnosing, monitoring and treating their own conditions will bring about a sea change in the traditional relationship between health professional and patient and the organisational structures of the NHS.

Underpinning all this is the hope that citizens in all walks of life will take responsibility for their own health and its maintenance. In some ways, this is the

Digital representation of the human genome American Museum of Natural History in New York City. Three decades from now, it will be routine for babies to have their genetic profile stored on a microchip for life. Faulty genes will be corrected.



most uncertain field of prediction, given the intractability of unhealthy lifestyles, addiction and health inequalities. Yet, surely future generations will look back with incredulity at newsreel footage of smokers, obese children and city centres swarming with binge drinkers.

With all these changes must be the imperative to transform global health inequality, with new generations of vaccines and the benefits of advanced technology and medical science.

Predicting the health and healthcare landscape on the 120th anniversary of the NHS, 60 years from now, requires a step into the kingdom of futurology. Here, what wonders could the “medicine of the impossible” yield? Walk-in, walk-out chambers which diagnose disease and then reset the body’s functions to normal? Replacement of diseased or aged organs with advanced tissue engineered or digital alternatives? Doubling of the human lifespan? The digitisation of the human mind?

The NHS has been remarkably resilient in absorbing 60 years of change in disease patterns and advances in medical science. There is every reason for us to be confident that it is a success story that will run and run.

Sir Liam Donaldson is chief medical officer

A personal history of the NHS

Kenneth Calman looks back over the past 60 years describing the impact that the NHS has had on him

I was born a few years before the NHS began and have been part of its progress over the past 60 years. For me, it has been part of my life, and it has saved my life. This is a personal history from someone who has been a patient, a carer, a professional and policy-maker.

My first introduction to the health service, at the age of nine, was the death of my father, aged 41, from a heart attack. He was a heavy smoker and his death occurred a few months after Richard Doll first published his key work on cigarette smoking and health. His death had a profound effect on me and, as my interest in medicine grew, it was clear that this event could have been avoided, or treated more appropriately.

Fifty-five years later, in 2008, I had an aortic valve replaced in the same hospital. I received impressive care from high-quality staff – from the surgeons, anaesthetists, nurses, dieticians and physiotherapists, and the whole, wonderful team.

What has changed in between? What would have happened to my father now? The increased range and effectiveness of treatments and diagnostic developments has been quite astonishing. In my own professional lifetime, I have been involved in transplantation, cancer therapy, palliative care and public health. In each of these areas, the outcomes for patients are now just so much better. And these are just in the fields I have been involved in. Other changes in childhood illnesses, child birth, heart disease, and mental health have been equally impressive.

The healthcare team is now well established, with the contribution of a wide range of professionals well recognised. Managing resources and making the best use of skills and expertise is now part of the ethos.

The involvement of patients and the public is critical, as I learned in my time as a professor of oncology. Patients and their families have so much to offer. We need their help.

The community-based specialties, including general practice and primary care, community child health and mental health, have been major successes. The management of the NHS has changed many times. Indeed, I have suggested that on formal occasions we might wear our campaign medals, for the reforms we have been part of: 1974, 1984, 1989 and so on. Quality issues now dominate the agenda.

Patients and the public want to know what will happen to them, what the outcome will be, and how that compares to other places. The watchwords are evidence-based, outcome-focused and quality-driven. Individual choice is important, and for some, quality of life may be just as important as length of life.

One of the most significant aspects of the past 60 years has been a huge improvement in public health. Standardised mortality rates in adults have dropped from 101 in 1950 to 57 in 2005. Infant mortality has decreased over the same period from 50 per 1,000 live births to 5 per 1,000 live births. In terms of individual diseases, for example breast cancer, the outlook is now significantly better, a 34 per cent reduction in mortality since 1989, with the introduction of screening, specialisation in cancer care, and improved treatment.

We have learned that health is determined by a number of factors, including our biological make-up, our environment, lifestyle, social and economic circumstances and the quality of our health services. It could be argued that health services (where most of the money goes) are the least important in improving overall population health. Employment, poverty and educational standards are all important determinants of health that continue to present challenges.

There are three other factors that have seen very significant changes over the past 60 years: the increasing relevance of research in showing ways to improve treatment and quality of life; the education of health professionals; and ethical issues, which are now seen to be increasingly relevant.

My first introduction to the health service, at the age of nine, was the death of my father, aged 41, from a heart attack

My final point is the important development, over the past 10 years, of devolved parliaments and assemblies. This has resulted in some significant differences in the ways in which health services and public health interventions are introduced, organised and delivered. These are healthy developments but, in the future, such differences may become more significant within the UK and policy-makers will need to think through the consequences. Their effectiveness, or otherwise, will need careful analysis.

To return to what would have happened to my father in 2009. First, I like to think that he would not be smoking. Second, with the role of primary care in identifying disease at an early stage, his condition might have been picked up earlier and prevention instigated. Finally, if he had collapsed at work in 2009, he would have had a better chance of resuscitation and acute treatment.

These are just some of the changes that have occurred over 60 years, and there are more improvements to come. However, in making such changes we should not lose sight of the fundamental principles of the NHS. The NHS is precious, it too needs care.

Sir Kenneth Calman is president of the British Medical Association and is a former chief medical officer

The unabridged version of this article and others in the supplement can be found on the website: www.policyforum.co.uk

Question time: the future direction of the NHS

Jonathan Dimbleby Good morning to you all. I am very glad to welcome Dawn Primarolo, Minister of State for Public Health; Andrew Lansley, shadow health secretary and Norman Lamb, who speaks for the Liberal Democrats on health. To start, I am going to ask each of them to give a kind of core message about the National Health Service (NHS).

Dawn Primarolo The NHS is more than an institution. It is part of the fabric of our society. It is a friend that touches us at times of basic human need, sharing our joy and comforting us in our sorrow. Rightly, people expect the government to protect its core principles. So, looking forward, the health service must become a 21st-century service, embracing new technology, brokering new relationships with its patients and staff, renewing itself in the face of new challenges, namely obesity, demographic change and chronic disease.

However, the true genius of the NHS lies in its capacity to evolve and confront dangers head on. It is about the brilliance of the staff who work tirelessly in the NHS. The big challenge ahead is for us to bring together the inspiration and commitment of the staff who work in it, with an understanding from patients of what to expect and what will be delivered to them, and to ensure that investment and reform take it forward as a winning

combination. In these challenging times, that has to be at the core of our discussions.

Andrew Lansley I think it is important for us to recognise, for the longer term, the importance of what the NHS has achieved for over 60 years. This is a sense of social solidarity based on the principle that people have access to healthcare according to their needs, not their ability to pay. When we debate the future of the NHS, if we lose sight of that core principle, it would deeply undermine a sense of equity that is one of the core foundations of social cohesion in this country.

My proposition today is that equity is not enough. What we also require is excellence. The NHS has achieved excellence over the years but we must now acknowledge that, too often, excellence in the NHS is the exception rather than the rule. We want to achieve outcomes that are at least as good as any other health economy anywhere in the world. If we are going to do that, we have to focus on outcomes. I think that one of the sins that has afflicted the NHS, as a result of the political process, is that it has been required to conform to bureaucratic and political objectives, rather than consistently remaining focused on achieving the best outcomes for patients.

Focusing on outcomes for the future will help us drive the commissioning of

services on behalf of patients with that objective in mind, and that will be a transforming influence across the service. We must liberate the staff of the health service, re-empower professions and professionals to deliver the best quality care and to follow wherever the evidence takes them in achieving excellence.

Accountability is not just to parliament; it is to patients. So, we have to give patients information, choice, voice and a structure that ensures that they feel this is a service they own as much as the professionals who work in it.

Norman Lamb I agree with everything that has been said in terms of the importance and value of the NHS. When you compare it with the other extreme, the system in America where 30-40 million people have no insurance and have second-rate healthcare, you see the remarkable power of the NHS as a concept.

In terms of the future, the biggest challenge of all is sustaining the NHS that we all feel very proud of and protective of. We have probably reached the end of the massive real-term increases in health funding, at least for the time being, and yet cost pressures within the NHS continue to rise substantially. We have an ageing population, we have the cost of new drugs coming through and we have lifestyle conditions, such as obesity, which could bankrupt the NHS. The



estimated cost of obesity is £45bn by 2050. So there is a perfect storm here. In the next financial year, we are spending £102bn on the NHS. We need to achieve sustainability and get more bangs for our bucks out of the available funding, achieving greater efficiency and driving up standards.

Jonathan Dimbleby Thank you. And so to the questions. Johnny Marshall is the chief executive of the National Association for Primary Care (NAPC).

Q Johnny Marshall “In light of the increasing costs of healthcare and an ageing population, how much longer will it be possible to provide a free comprehensive healthcare service at the point of delivery?” Many primary care trusts (PCTs) have deemed low-priority procedures to be not available locally. There is not necessarily a national policy around that or a marker as to what should be available. So I wonder, as that grows locally, whether we will have to reflect that in a national policy.

A Andrew Lansley I do not see a fundamental reason why we should not be able to sustain a free and comprehensive healthcare service. However, when you compare resources deployed for healthcare in this country with other countries, we are approaching a European average, but there is still a significant gap between us and, for example, France or Germany.

In America, healthcare spending is at nearly 15 per cent of gross domestic product, compared to 8-9 per cent in this country. Yet in America the debate is not about how they can cut back on their healthcare spending. The debate is how they can achieve universal access to it. There is excellent healthcare in America. The problem is that it is not equitably distributed. Our issue is that we have equity but we need to acquire excellence.

Jonathan Dimbleby Given the likely economic future, are you saying it is possible to find more resources in real terms?

Andrew Lansley Every developed country spends a greater proportion of its wealth on healthcare as it gets richer. There is a perfectly valid argument – I just do not happen to agree with it – that the most efficient way of spending that money is to insure base systems so that you empower



individual consumers. My personal view is that we should empower consumers within the NHS, for reasons of equity.

Norman made a valid point about obesity and so on, but let us remember this: when the Foresight programme talked about £45bn, one-seventh of that was an NHS cost. Six-sevenths of that cost was outside the NHS. It is a big cost but it is not break-the-bank time, especially if we were to have a more efficient public health system that focused on that.

Norman Lamb My ambition is to find ways of securing a free comprehensive healthcare system and that is why I talked about the importance of achieving more bangs for our bucks. PCTs are already making decisions about high and low priorities. The problem I have is that there is no accountability for those decisions. There is scope for people to determine what priorities there should be and how much they spend on particular areas of healthcare locally but there has to be local accountability for that. That is why, as a policy, we argue for commissioning locally to be nationally accountable.

Dawn Primarolo We need to look at the combinations of opportunity, whether that is about technologies that enable us to do things more efficiently or prevention in understanding the trends for our health. If we look particularly at our ageing population, we need to look radically at how we can try to move away from that acute intensive care model that old people often find themselves trapped in.

Sixty years ago, we did not have an understanding of the true health of the

nation. We are now catching up with that and we understand the major trends and challenges. The driver is having a local authority requirement of duty and for local authorities to look at the well-being of their local communities, in partnership with the local NHS and with other providers of services.

Andrew Lansley Why do you not take our policy, Dawn? It is joint commissioning of public health services, with a separate public health budget administered by the health service and local authorities together. To be able to do that across the whole of the public services is an integral component to try and deliver effective public healthcare.

Dawn Primarolo My view is that partnership through local authorities, with a duty to have a transparent and accountable assessment of the well-being and health of their local population – which is the way we are proceeding with the NHS Bill proposals that will be before parliament – is a better way to assess that care within the framework of the draft constitution. So you can say, “This is what you are entitled to.” Your proposals on public health fail to understand the interactions and complexities of the NHS. People should also have information that informs what others should do in having a duty to reduce health harms so that the NHS is not at the end of the queue dealing with the problem.

Q Jonathan Dimbleby Dr Gary Bolger, head of medical policy at AXA PPP Healthcare has asked: “Does the panel believe that allowing

patients to buy drugs that the NHS will not fund will benefit the population of this country (as recommended in the report by the cancer tsar, Mike Richards)?”

A Norman Lamb I supported Mike Richards’ report. Can we legitimately say to someone who has been advised by their clinician that a particular drug will be of therapeutic value to them, but which their PCT refuses to pay for: “If you follow your clinician’s advice, we will withdraw the care that is offered to you by the NHS.”? That is the situation I was faced with regarding a constituent. The PCT told us they would withdraw his care if he followed the advice of his clinician from Addenbrooke’s.

Jonathan Dimbleby It does mean you are shifting the definition of “comprehensive”, but not to mean, “I can go over the GP whenever I want to.”

Norman Lamb Allowing people to pay for additional things beyond what is on offer from the NHS seems to be the only legitimate response in a free society. Taking away the NHS offer because people do something with their money seems to

me to be extraordinary and unsustainable.

Jonathan Dimbleby Andrew, you support the Mike Richards proposition too. Does it not mean that the challenges to the term “comprehensive” will become even greater when the system is under pressure?

Andrew Lansley Mike Richards’ report proposes that the NHS should not withdraw care from people who have accessed medicines that the NHS has refused to make available to them. We said that was our view before the report came out. That does get you to the point where there is a risk that the NHS is not a comprehensive service.

The proposition that the NHS decides that you are on your own and you have to fund your own life-extending care does not seem comprehensive and it does not seem a basis on which we expect the NHS to work. What Mike Richards bolted on to his report but could not control were the issues of drug pricing and getting medicines into use in the NHS. Mike Richards clearly said that introducing a value-based price was something that needs to happen. We are talking about how we do that.

The other part of it is making sure that the assessments that we use – in terms of the value that the NHS should contribute to medicines through the NICE processes and the threshold – properly understand the benefits that are being offered, including societal benefits and the like.

We made proposals after Mike Richards reported in early December on how we would form NICE to help to make that happen too. The objective is that clinicians should be making decisions, whether they are GPs commissioning or consultants providing services. If something is in the best interests of a patient and is the most clinically effective option, clinicians should be empowered to provide that service.

Jonathan Dimbleby A Labour government committed to a comprehensive healthcare system endorses a proposal which means that you get the treatment if you can afford it and you do not get it if you cannot.

Dawn Primarolo No, I do not think that is what Mike Richards’ proposals do. It has always been the case that people who can afford to can go off and buy treatment privately. The issue was about the universal availability of drugs in the NHS

Future NHS is a service commitment, not an organisation

By Niall Dickson

There are three timeless questions around which the debate on our healthcare system is likely to be conducted for the next 60 years, as it was for the past 60. How will we pay for it? On what will we spend the money? How do we achieve better value for that money?

From its earliest days, the health service has faced the charge that it is unaffordable, yet it remains resilient and popular and, in recent years, the electorate has been willing to pay more in tax on the promise of a better service. My guess is that the current settlement will survive for at least the next 20 years, although it will certainly come under pressure when, again, the NHS must learn to cope with funding levels that do not match rising demand.

From Bevan’s state-owned, state-funded, state-run institution, we are moving towards the NHS being a promise rather than a single organisation. The promise will be of high-quality, free care for all, which can be delivered by a range of organisations, some for profit, many not. Already in England more than half of the hospitals and mental health services are independent foundation trusts, accountable to an independent regulator.

The NHS is largely a service for elderly people and that is not about to change, although the next generation of older patients will be more demanding and better informed than the last. What is spent will be influenced by what is possible, as our ability to fix and repair organs as well as joints, to target therapies and use genetics to understand the nature of disease grows. A great deal will depend on our ability to respond to the lifestyle challenge. It

may be that this will be a time when prevention really comes of age – although we need better evidence of what works.

As to how we drive up quality of care and treatment while containing the growth in costs, the health service in England is now using just about every form of incentive imaginable, but it is less clear whether any of them are working optimally or are the appropriate incentive for the right service.

We have a contracting system that sometimes enables providers to compete to provide a service; we have a regulatory system that monitors and benchmarks their performance; we also have a regulatory system for each profession. The interesting feature of all this is that no one form of incentive is dominant. If current trends continue, there will be more reliance on benchmarking. There will also probably be more competition, partly driven by Europe, partly by patients demanding choice.

It is likely that the medium-sized district hospital will wither as clinical evidence and patient convenience cause some services to be centralised and others to be offered more locally. In the longer term, location for some aspects of care will matter less – even complex operations can be carried out remotely – surgeons in the US have operated on a patient in Paris. We should not fear leaders who wish to change the NHS as we know it, but we should be sceptical of those who claim that maps of local health bodies need to be rubbed out and redrawn in order for services to improve.

Niall Dickson is chief executive of the King’s Fund



Mike Richards clearly said that introducing a value-based price was something that needs to happen. We are talking about how we do that.
Andrew Lansley

and whether or not, when somebody chooses to have private medication, they should then lose all access to the NHS.

What is available in the NHS has to be clinically effective and cost-effective. That means looking at what works. I spoke to a constituent recently who wanted to try something on the basis of “any hope will do” even though the clear medical evidence was that it would not work. We have to deal with those patient concerns.

We need to say, “Do we have a transparent process through NICE which gives us clinical effectiveness and cost-effectiveness?” A lot of proposals came out of that about the interaction necessary between the development of drugs and their assessment in a timely fashion by NICE so that, by the time those drugs come on to the market, they are guaranteed if they are cost-effective and clinically effective to the NHS.

When you are assessing drugs that might lengthen a person’s life for a few months or a few years, the interaction that applies is crucial. Changes have been agreed now. The relationship between the development of drugs coming to market and NICE’s assessment must be transparent. The patient must be told. Where there is not a NICE recommendation, the process that PCTs use must be standard and transparent so that patients understand. Nobody should be denied access to a comprehensive health system by virtue of the fact that they have bought something personally that is not used in the NHS.

Jonathan Dimbleby Flowing from that we have received a range of questions that

relate to NICE’s responsibility, reconciling public concerns about the postcode lottery or local focus and commissioning. Our speakers will be posting their answers to these on the *New Statesman*/Pfizer policy forum website [see page 15].

I will move on sharply to the role of the independent sector. David Wright, chief medical officer and clinical director for occupational health at Atos Healthcare, could you pose your question?

Q David Wright “What are the future intentions for the use of the independent sector in the NHS, not as an alternative to the NHS but as a supplier to it. What would be the aims of such involvement, and what is the experience so far?”

A Dawn Primarolo The aim is for the NHS to deliver the care that patients need at the quality that we should be able to protect, guaranteed around the principles of the NHS. This government has shown that where it needs to bring in extra capacity or an organisation leading that care, which can provide to those quality standards, we will engage with the private sector. Some contracts, for instance (which I am not going to discuss now because they are coming up) are for the independent treatment centres and the way that helps us cope with the waiting lists.

Jonathan Dimbleby Is there any bar in the future to the independent sector providing any level of care, any level of provision, so long as it is competitive with the price that the NHS can offer?

Dawn Primarolo Of course, there is a role. Are we saying “Never a partnership”? Of course not. We are going forward now, buying in the expertise, whether it is diagnostics or management.

Can that become all-encompassing across the NHS in terms of being the major providers? The answer is that I do not think so. I would not support that because I think the NHS is a public service buying in expertise, and we do that all the time, across the whole series of healthcare and always have.

Norman Lamb As a Liberal I do not believe in a state monopoly. For me, the issues that matter are quality of care, access without charge and value for money. I do not have any difficulty with other providers playing a role within the NHS and I do not think it would make sense to have a quota after which point you must stop.

I strongly support developing the role of social enterprises. There is a very exciting development in Surrey with nurses and therapists who have taken over community services – a co-ownership arrangement – with 780 staff jointly owning this and providing those services. The great potential value of social enterprises is that you combine the public-service ethos with a cleanliness of foot, a capacity to innovate and to meet new challenges.

Jonathan Dimbleby That does suggest, in principle at least, that the NHS could end up as a standard-setting agency, with those standards being met by an independent or a social-alliance sector, delivering at a cost that can be afforded, with patient choice saying, “That’s where we want to go.” Is that possible?

Norman Lamb I believe in a mixed economy. I suspect that state provision will always play a significant role in acute hospitals, for example, and in research centres and so on. In the French system, which is highly regarded internationally for its quality of care, a lot of the hospitals within the state system are privately owned and run. We have to focus on what is important to patients. It is the quality of the care and whether the taxpayer is getting value for money.

Andrew Lansley I am pretty much in the same place as Norman is on this. It is not just about standard setting. The important

work here is commissioning. The job of the NHS is to commission services on behalf of patients and to secure the best possible care. So it is about quality, value for money and standards ... and much more than that. It is the management of care of patients and ensuring the best providers are secured.

If we are not careful, we end up dancing on the head of a pin, saying, "If there were to be a mutual organisation in the NHS owned by its staff, would that count as a social enterprise or would it count as an independent enterprise? If it happens to become a limited company, does that automatically disbar it from any kind of access." What we should say is "any willing provider".

In what Dawn had to say, there was a telling phrase about using the independent sector for extra capacity. But that is not the way it works. You create as level a playing field as you can and then you allow NHS clinicians to access services in the best possible way on behalf of their patients.

Dawn Primarolo I do not agree. I think the challenge is set in the health service and the breadth of our understanding of interaction with care and prevention, and the commitment to the core principles. It is a public service and we need certain things to be going on within that.

Norman Lamb In social care local authorities have become mainly commissioners. There have been enormous innovations in social care that have not been so apparent in the health service.

Dawn Primarolo I think that you and Andrew are agreeing that somehow the NHS can be lifted up, put somewhere else and become just a list on a page about what needs to be delivered and then we can contract that or commission it. I am saying it is more than that because of the relationships we manage. There are lots of interactions. It is much more complex.

Jonathan Dimbleby Some might detect a serious ideological division between Labour and the other two parties on this.

Dawn Primarolo I think there might be.

Jonathan Dimbleby Our next question takes us to the heart of some practical questions. Richard Davidson is director of policy and public affairs at Cancer Research UK.

Richard Davidson "Almost 200,000 11- to 15-year-olds smoke and eight out of ten smokers start before the age of 19. How would the panel tackle smoking and monitoring people and reduce tobacco marketing towards children?"

Norman Lamb First, I would make it a criminal offence to buy tobacco to pass to an under-age smoker. Currently that is the case for alcohol but not for smoking. Second, there is a massive problem with smuggled tobacco. One of the problems of using tax and price as a lever to achieve public-health objectives is that that is undermined, particularly in poorer communities, with an enormous volume of tobacco that is smuggled into the country and sold at very low prices, especially rolled tobacco.

Next, I think there needs to be action on vending machines. We know that a lot of youngsters, under-age smokers, get their tobacco from vending machines. We have not reached a final view but I think there is an argument for saying that you should just ban vending machines because there is clear evidence that that is where children get some of them from.

I have doubts about an absolute ban on displays in shops. I am a Liberal. At the end of the day, I want people to make informed choices. Ultimately, if someone wants to smoke, society should not stop them from doing that. There is nothing wrong with choosing to do that. The state can intervene where someone's actions have a negative impact on other people, so the protection of children is absolutely key. However, I am in favour of further restrictions on advertising at point of sale, which there has been a

focus on from the tobacco companies.

Andrew Lansley I would not really dissent from the things that Norman was saying except that I do have a concern about the withdrawal of vending machines in circumstances where only over-18s technically have access. It seems to me that you would start to trespass over the dividing line where one could say, "Are we trying to stop people doing something that is perfectly legal by creating barriers to prevent them doing it?"

If it is legal for people to smoke over the age of 18 – and, in legislation, we have agreed that that is the threshold now – there is a limit to how unreasonably you can restrict people from doing it.

Actually, there is a broader issue on public health about young people taking a different attitude towards those things that will do them long-term harm, such as binge drinking, smoking, drug abuse or unprotected early sex. On all of these things, positive peer pressure creates positive results in terms of young people taking the decision not to do things that will have long-term damaging consequences.

Dawn Primarolo I think we have an absolute duty to protect children. The debate around smoking gets confused, jumping from adults being able to take a decision but then attacking or criticising the measures that protect children. We know that 87,000 people a year die from smoking-related diseases. We know that seven out of ten smokers want to stop smoking and need the support of the health service to do that. We also know that the overwhelming majority of those who want to quit say they started smoking when they were children.

They can call me "nanny" or whatever they like. We have a duty to protect our children and we should not back away from that
Dawn Primarolo



Tackle funding, organisation and priorities head on

By Charles Wolfe and Naomi Fulop

Is there a case for a government-funded health service in the 21st century? The short answer has to be yes, but current uncertainties around funding, organisation and priorities need to be tackled head on if confidence is to be restored in the public, the healthcare workforce and its observers internationally.

The NHS needs to address several challenges in the next decades: huge demographic changes that are likely to continue for the next 50 years; new “epidemics” relating to complex social changes (in particular, obesity); advances in medical interventions and technologies; and continuing increases in public expectations. Mortality may be declining from some of the big killers, such as heart disease and stroke but, with an ageing population, we are seeing an exponential rise in the need for preventive and curative health services, along with social-care needs that government has failed to tackle in a joined-up fashion. We need skilful mining of governmental and NHS data on the sociodemographic profiles of populations and their change over the next 50 years.

Public expectations are likely to continue to increase, especially as the baby-boomers reach old age. To enable choice, access and quality issues to be addressed effectively, we need health solutions based on robust analyses of population data, and centred on the individual in society.

Prevention is said to be better than cure, yet solutions are thin on the ground in cardiovascular health, cancer and mental health. In some areas, the broader inequalities in health are worsening. Any government serious about reducing these needs to implement

major strategies to tackle the well-known wider determinants of health, such as education and employment, rather than expecting the NHS to reduce inequalities, as is currently the case.

Balancing priorities arising from rapid development of expensive drugs and treatments will be increasingly difficult. The NHS currently responds rather randomly to emerging evidence on drugs, medical devices, and novel technologies. There are incredibly tortuous and lengthy processes to get new drugs and devices into clinical practice, yet novel approaches to minimal-access surgery have pretty low hurdles, diffusion into practice moving often uncontrollably swiftly. There is also a bottleneck blocking good innovative ideas on the ground in the NHS being developed into a product the NHS can use. There are supportive proposals to facilitate innovation in the NHS but the bureaucracy associated with innovation must not be allowed to stifle it.

However, the NHS should not just focus on improving medical technologies but also on putting “patient experience” at the fore, such as making services more accessible or improving communication between patients and professionals.

Ways of improving implementation of evidence into practice for both clinical and service innovations are required – developing more sophisticated financial incentives might facilitate this.

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The research from the UK and the international work that has been done on this has said that, as the governments have pressed ahead with controlling advertising, the promotional activities around point-of-sale have increased. Cigarette companies pay to have their products displayed in that way and they would not be doing it if there were not a point. The point is to prompt and encourage.

The BBC did a vox pop in my constituency this weekend, which they showed me when I did a live interview. They stopped people and asked, “Do you agree about this point-of-sale issue?” and even smokers agreed.

Young people will continue to try smoking. About 350,000 of under-16 year-olds choose to smoke. Thankfully, that number is going down, but the 200,000 regular smokers aged 11–15 need to be dealt with. That means making sure that there are promotional activities and that is what we are pressing ahead with. It means restricting vending machines, particularly where we believe they give more access to young people. If we cannot stop that access, that may lead us to the conclusion that we should ban vending machines.

The overwhelming users of these

vending machines are children. Given that we know the consequences of smoking, we have an absolute duty to protect children. We have to deal with promotion, we have to deal with vending machines, and we have to make sure that we are getting the right advice through. We have to support GPs in the work they are doing and make the services which support people who want to give up smoking as widely available as possible. It also means tackling contraband.

Jonathan Dimbleby Can you give a quick reply on whether it should be a criminal offence to sell tobacco to under-age children?

Dawn Primarolo I do not think of this often as a positive way forward. I understand the attractions. I think what we have to do, looking at the evidence, is try to help people not to start smoking in the first place. That means targeting children. I do not care what people call me. They can call me “nanny” or whatever they like. We have a duty to protect our children and we should not back away from that.

Jonathan Dimbleby Arising out of that,

there is a host of questions that we cannot deal with in the time that we have left on heart disease and cancer, all important policy questions addressed to all the panel members. Responses to those questions will be posted on the website.

I am going to go to a slightly different area, relating to emerging technological and scientific understanding and the impact that has on the health services of the future. Professor Steve Humphries is British Heart Foundation professor of cardiovascular genetics at UCL.

Q Steve Humphries We hear weekly that scientists have identified genes that cause cancer, heart disease, Alzheimer's and even obesity. My concern is that I do not know where the funding is coming from to implement this in the NHS. “What are the views of the panel about where the funding mechanism for the “D” part of NHS research and development (R&D) is coming from?”

A Andrew Lansley I am glad to say we have an NHS R&D programme that has substantially increased and which is focused on R&D and not just on

service support. In terms of funding mechanisms, in so far as it is part of the preventive agenda, it could be commissioned through a public health service in that sense. It is not necessarily PCT commissioning – do we need it to be commissioned nationally or do we need it to be commissioned regionally, sub-regionally or whatever? If there are separate public-health resources, they facilitate that happening because prevention can be weighed on its own merits, as opposed to constantly being siphoned off.

Importantly, there is also the question of doing gene testing in considering the issues for familial links, and so on, which probably requires a new commissioning mechanism. For example, if somebody is diagnosed with a disease in Lanarkshire and their family lives in Wiltshire...

Steve Humphries That is exactly the point.

Andrew Lansley ...will the Wiltshire PCT spend money where they have nobody ill? For the NHS, it may be a priority because it is part of the preventive agenda but it is not population prevention or primary prevention. It is highly-focused prevention and we do need mechanisms for making that happen.

Dawn Primarolo Interestingly enough, one of the reasons why I have to go shortly is because I am in front of the Select Committee on genomic medicine, which is looking at the framework and structures we need to have in place to go from bench research through development into patient benefit. It is about how we secure funding for the research. There is also the translational research, if I can call it that.

I will do a longer answer on the website about why I think we have got the funding in place, but let us come back to the wider question about the NHS and its importance. The NHS gives us a huge amount of information about the population's health and it also offers, picking up the point that Andrew made in terms of clinical trials, an understanding of what works, and having that quick transmission of benefit to availability open to it. We did make a huge amount of investment in the genome work originally – which we are still doing – and it has to be done by the Department of Health through the work that the excellent Professor (now Dame) Sally Davies is doing in refocusing the universities, in partnership with the Wellcome Trust. It is about making sure that we are pulling those ideas through and then translating them as rapidly as we can into patient

benefit with all the things that you rightly identify need to be done. That is another way of making the health service sustainable for the future.

Norman Lamb I do not think there is too much disagreement from the panel on this. It is interesting. I strongly support quite a radical decentralisation of power and accountability within the NHS. But research and development is one of those things where it makes sense to have a national focus because of the benefit across the whole of society and in terms of using the available resources as efficiently as possible. So the day-to-day operation of the NHS should be heavily decentralised, but things like research and development should be directed far more at the national level.

Jonathan Dimbleby Thank you. We can just squeeze in one more question, which is a very practical and highly contentious issue, put jointly by Jane MacDonald, who is president-elect of the British Renal Society, and Fiona Loud, who chairs the Kidney Alliance.

Fiona Loud I would like to ask the panel: "What measures are in place to assess the effectiveness of the current organ donation programme

Old battle lines between public and private are now blurred

By Jennifer Dixon

Last summer, for the 60th anniversary of the NHS, the Nuffield Trust published a book in which key former secretaries of state for health gave their views as to whether the NHS should "rejuvenate or retire". There was considerable consensus on four particular points.

First, there was strong public support for the collective value underpinning the NHS – fairness. Second, that funding by taxation would remain for the vast majority of the population. Third, that the NHS was too big and too complex to be run by politicians. Fourth, that there should be a diversity of providers (not just those owned by the NHS) offering care to patients, and that some level of competition between them was healthy.

The recent advice to government by Mike Richards, recommending that individuals be allowed to pay privately for care not available on the NHS, without losing NHS entitlement, opens the door to allowing more people to supplement tax-funded care with privately-funded care. Former secretary of state Stephen Dorrell noted, "What has changed is the balance between the collective and the individual in society...and that is a challenge for the health service. To recognise that is not to walk away from its collective aspiration which...is overwhelmingly right."

The old battle lines, between those on the left, who believe in more funding, greater central or local democratic control to achieve improvements, and those on the right, who believe in privatisation and competition, are now very blurred. The debate is

now essentially about two related things: power and levers.

First, what is the right blend of levers? In England, the political battle over the merits of allowing non-NHS hospitals and clinics to provide care to NHS-funded patients, and paying them according to the number of patients treated, has largely been won. This is still not the case in Scotland or Wales. Regarding direct financial incentives, central direction, regulation, local accountability, and encouraging stronger professionalism, research evidence is often not strong enough to give real-time answers as to where to go next. Instead we are left with experience (largely the domain of civil servants, managers and the few clinicians who engage in reform discussions) or instinct (largely the domain of politicians). While this can lead the NHS up some blind alleys, the long-term direction in England is surprisingly similar to that seen in other health systems across the OECD.

Second, to what extent should power be shifted from Whitehall and distributed locally to allow more innovation to flourish? Some argue that we need to break it up into manageable chunks; others argue that that will reduce fairness in access. So far the most meaningful step to allow local autonomy has been to liberalise hospitals – over half now are foundation trusts, where there is a legal lock to prevent Whitehall from interfering. The obvious future battle will be whether NHS commissioning should be similarly autonomous.

Jennifer Dixon is director of The Nuffield Trust

over the next five years? If it is found not to be achieving its goal of raising organ donation by 50 per cent, are there plans to address this during the programme rather than wait until the end?" My personal experience tells me that five years is too long to wait.

A Dawn Primarolo The answer is, yes, there are measures in place and, yes, we will monitor them over that period as well. Within the five years, the Secretary of State has made it clear that if it became clear that we were not going to achieve the availabilities, then we would return to the question of, for instance, presumed consent. Hopefully, next month I am going, at the invitation of the Spanish minister, to look at the developments they are making in ensuring that the crucial link is the work that medics and health professionals do with the families of those who could be potential donors, as well as whether or not you are on the list.

What the Spanish example appears to show us is that, although they have presumed consent, it was only once they started taking the other steps that they saw the benefits. The health minister has put much more emphasis on the other steps than presumed consent when he has spoken to me.

Yes, steps are in place; yes, we will monitor and, yes, we will act before the five years are up.

Jonathan Dimbleby Norman and Andrew, if it shows that there has not been a 50 per cent improvement as hoped, what happens then?

Norman Lamb I suppose moving to presumed consent. I fully accept that it has to be part of a package of measures. Interestingly, my colleague, Jeremy Brown, has come out quite high up on the private members' bill list. He has decided to go for a bill providing for presumed consent, and I have confirmed that I would support it as a sponsor of the bill. He has all-party support for that bill now. I was very disappointed that, in the review that the government initiated, the recommendation that came back to the government was against presumed consent. I think it is the right thing to do, along with a package of other measures.

Jonathan Dimbleby If the recommendation had been in favour, would you have gone with it?

I strongly support quite a radical decentralisation of power and accountability within the NHS **Norman Lamb**



Dawn Primarolo I have my personal views. I will stick to the fact that I am saying what the government's view is now.

Jonathan Dimbleby For the benefit of readers, I will state your personal view for you but it is not attributable. The minister would wish it possible to go straight there now – and she has not dissented. Andrew, what would you do, given the circumstance in which you do not get the uptake that is sought?

Andrew Lansley Although we debate this as representatives of our respective parties, it is always a free vote.

It actually is only about four-and-a-half years ago that parliament debated this matter very thoroughly. Then, the view of ministers, in part informed by the experience in Spain, was that presumed consent was not the basis on which they had improved their overall level of organ donation.

There is a study in the *New England Journal of Medicine* that says that, on balance, across the world, those systems with presumed consent have slightly higher organ donation rates.

However, there are countries that do not have systems of presumed consent which have very high organ-donation rates relative to ours. Ours is exceptionally poor. So the proposition that there are many things that we can and should do that would raise the level of organ donation is one I heartily subscribe to.

In my constituency there is more transplant activity going on than anywhere in the world. I am a patron of Transplants in Mind, but I have to say, whatever the outcome – clearly there are many things we should do – I do not think that it is right to go to presumed consent.

We have legislated under the Human Tissue Act for the principle of informed consent to be the basis for the way that the health service and our public services use people's organs and tissues.

Jonathan Dimbleby Is that because you believe that there is a sense in which someone owns their body after their death?

Andrew Lansley Not legally, of course. I take the same view as John Reid did, who was secretary of state during the passage of the Human Tissue Bill, which is that the one conclusion we should not arrive at is that people believe that the state owns their body after their death, and that informed consent must be the basis on which we act.

I have discussed this with transplant nurses doing the kidney transplant programme at Addenbrooke's and they say, "What's the difference? The government is saying that we will have presumed consent but we will actually discuss it with the family if there is not already prior consent from somebody before their death or they are not on the organ-donor register. If the family has objections, we will not proceed." So, presumed consent makes no difference because that is exactly what should be happening, anyway.

Jonathan Dimbleby We must stop now. I just need to say thank you very much for the open and candid discussion that we have had here from our three panelists, which I found really enjoyable. I apologise to those whose questions we could not reach. However, the website will be available. Thank you very much for your questions and for being here.

Putting quality care first

Safe, effective, patient-centred care and a focus on healthier lifestyles are key elements for a NHS fit for the 21st century, writes *Ara Darzi*



Since its creation in 1948, we have seen the NHS make great contributions to the quality of our lives. There is no doubt that we have come a long way, but it also shouldn't come as a surprise that things are changing. Exactly what the future has in store for us is always uncertain, but we do know some things for sure: healthcare costs are rising, people are living longer into old age, often with chronic conditions, and our expectations as patients have increased dramatically. These challenges are common across the developed world – the question for us is how to respond to them.

The history of recent healthcare reform shows that we are rising to the challenge. Ten years ago, the NHS operated on a standard that required treatment to take place within 18 months. This was painful for patients and the clinicians caring for them, and both patients and taxpayers quite rightly expected better. In the past decade the government responded to this by trebling its investment in the NHS. The results of this can be seen clearly, not least in an increase of staff, which has included 80,000 more nurses, 40,000 more doctors and 19,000 other healthcare professionals, such as physiotherapists and occupational therapists. Essential as it was, we also know

Patients need to be active partners with professionals in defining their needs for care, not passive recipients of the decisions of others

that this investment alone will not be enough to deal with the challenges that still lie ahead of us.

First, I believe that we need to put quality of care at the heart of the system by making it the guiding principle for everything we do. Providing my patients with high-quality NHS care has been my ambition throughout my career – just as I know it is for hundreds of thousands of other staff. My recent report (*High Quality Care for All*, June 2008) defined quality care as something that should be as safe and effective as possible, and which considered patients' experience from the point of view of their pathway of care – a point of view that does not recognise the boundaries that we clinicians often create between primary and secondary care. This was the main thrust of the Next Stage Review that I led and which we are now implementing. Every single member of staff has an important role to play in contributing to this, and it will only be possible if they are both empowered and accountable, allowing them the freedom to lead and manage the organisations in which they work.

Second, patients should be able to shape the system and the services they use. I have seen through my own work how much better a patient responds when they feel that the clinicians and staff are look-

ing after them as individuals and involving them in choices about their treatment. This is why I believe that patients need to be active partners with professionals in defining their needs for care, not passive recipients of the decisions of others. We have already seen the benefits that personal health budgets can have in social care and I want to push ahead with exploring how this model might work across other parts of the system. If we are going to have an NHS that is prepared for the future it will need to be one that can respond to the needs of individuals and society with compassion and understanding.

Third, we need to be far more focused on preventing people from needing to enter the health system in the first place. We have high-quality hospitals, clinics and mental health services up and down the country for when we need them but at the front of our minds should be how to reduce the number of people who develop illnesses and need to go into the system in the first place. Much has been written about the rise of “lifestyle diseases” recently, such as obesity, and I believe there is so much more we can do to help people make healthier lifestyle choices. However, a challenge such as rising obesity will not be solved by better hospitals – instead the NHS role in this is to change how we interact with the public through primary care. I have a high regard for the services already being provided by GPs and community health professionals, and I believe there is scope for them to do even more to help people in their communities to live healthier lives.

We know that there is still much more to improve, and that we must act if we want to achieve our ambi-

Quality is not a byword for luxury – it is the key to a safe and efficient NHS that provides the high standards of service that every member of our society rightfully expects

tion of having an NHS fit for the 21st century. President Barack Obama wants the US to embark on its own journey towards universal healthcare. Talking on the subject at the Families USA Conference a year ago, he made a comment that I believe is just as applicable to us: “We must act. And we must act boldly...the most expensive course is to do nothing.”

In these tough economic times we must remember that quality is not a byword for luxury – it is the key to a safe and efficient NHS that provides the high standards of service that every member of our society rightfully expects. If we can focus on driving up quality, joining up services and preventing avoidable ill health, we will be able to make significant savings.

The NHS should be proud of the progress of the past 60 years and the contribution it has made to our society. It has provided a great legacy for us to build on and we want to make certain that we continue to support it, taking care not to undermine the values and passion of the 1.3 million staff across the country who deliver services to patients. The response from over 60,000 staff and patients who we engaged with during the Next Stage Review has set a clear vision for high-quality services. It is vital for the well-being of this country that we make this vision a reality.

Lord Darzi led the 2008 government review High Quality Care For All. He is Paul Hamlyn chair of surgery, Imperial College London, and honorary consultant surgeon, Imperial College Healthcare NHS Trust and the Royal Marsden Hospital NHS Foundation Trust

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The unabridged versions of all the articles in this supplement can be found on the policy forum website. The authors are:

- Kenneth Calman, President of the British Medical Association
- Ara Darzi, Parliamentary Under Secretary of State at the Department of Health and Paul Hamlyn Chair of Surgery at Imperial College London
- Niall Dickson, Chief Executive, Kings Fund
- Jennifer Dixon, Director, The Nuffield Trust
- Liam Donaldson, Chief Medical Officer
- Charles Wolfe, Professor of Public Health and Head, Division of Health and Social Care at King's College London, and Naomi Fulop, Professor of Health Policy and Director, King's NIHR Patient Safety and Service Quality, Centre at King's College London

In addition to attending the question and answer debate, panel members Dawn Primarolo, Norman Lamb and Andrew Lansley have kindly agreed to answer all the questions that were submitted to the *New Statesman* as part of this collaboration with Pfizer.

This includes questions submitted by the following:

- Gillian Leng, Deputy Chief Executive, NICE
- Cathy Ratcliffe, Deputy Director, HEART UK – The Cholesterol Charity
- John Coulthard, Director of Healthcare, Microsoft Limited UK
- David Worskett, Director, NHS Partners Network
- Steve Williamson, Consultant Pharmacist in Cancer Services, North of England Cancer Network
- Steve Field, Chairman, Royal College of General Practitioners
- Vincenzo Libri, Head of Clinical Studies, Imperial College London
- Ruairi O'Connor, Head of Policy and Public Affairs, British Heart Foundation
- Martin Jones, Head of Public Affairs and Campaigns, Breakthrough Breast Cancer
- Richard Blackburn, Head of Primary Care, Pfizer
- Maura Buchanan, President, Royal College of Nursing
- Karol Sikora, Medical Director, CancerPartnersUK
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