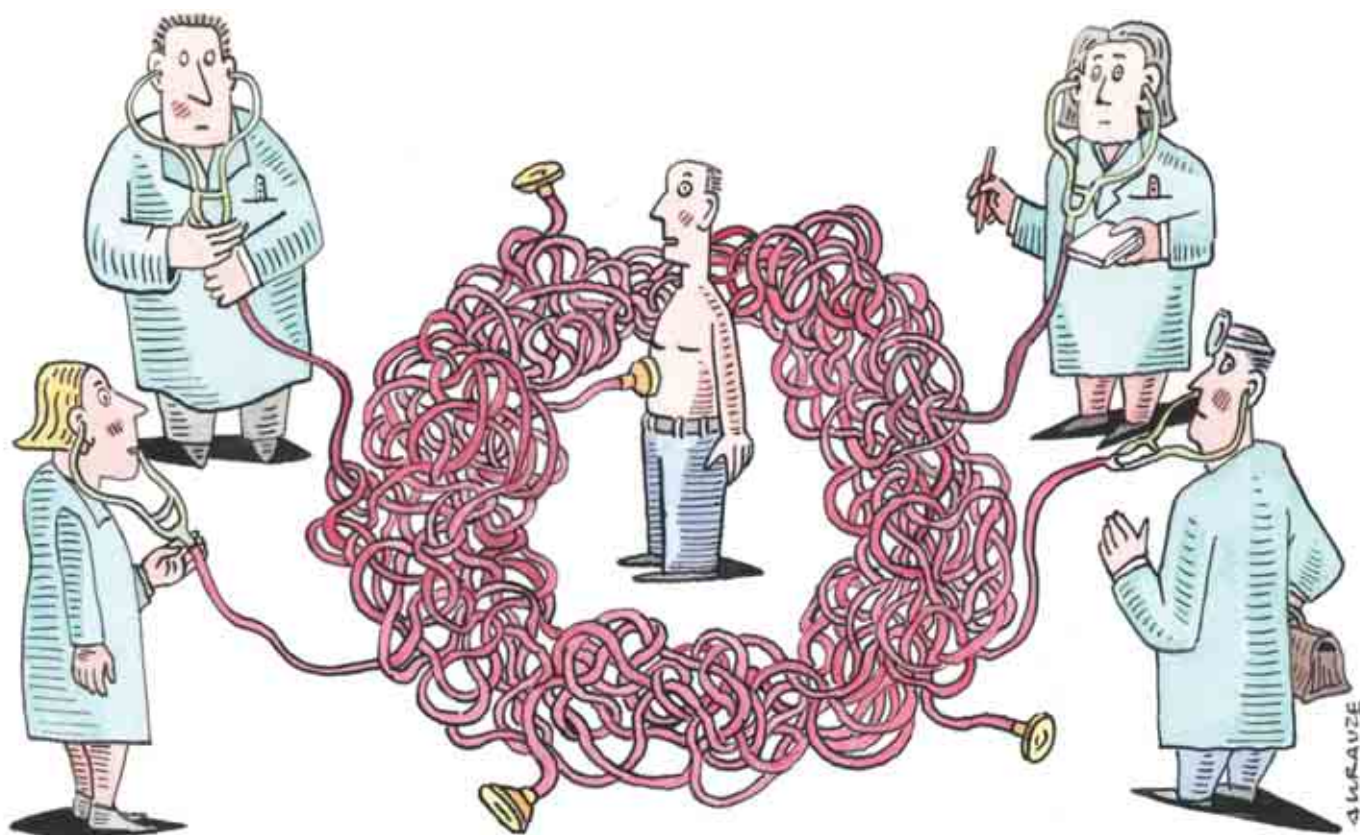


NEWSTATESMAN



DEVOLUTION IN PRACTICE: HEALTH POLICY



A summit on devolved national health services in the UK

Devolution and the NHS

Divergence in devolved healthcare services has had a relatively easy run but, if Labour's majority in each region is lost, it may challenge this peaceful co-existence of services

By Olivia Lang

When the NHS hits its sixtieth birthday in 2008, Bevan's original creation in post-war Britain will be almost unrecognisable. Devolution of power has had a profound effect on healthcare structure and increasingly divergent strategies have evolved throughout the UK, providing solutions to local problems while, simultaneously, creating tensions. Although the sector has seen a number of structural changes

since its conception – such as in 1974 and 1990 – Labour's ambitious division of central power in the late 1990s has translated into increasingly autonomous policy units, each with its own healthcare direction.

Permissive Labour

It is hardly surprising that the new institutions have led to the emergence of divergent models of health services. Although marginal differences existed before, Labour policy in Scotland and Wales had been to not highlight differences and splits. Labour's policy after devolution has been incredibly permissive in allowing countries to get on with following their own priorities and policy direction. While powers vary between the devolved bodies, such as the ability of the Scottish Parliament to increase taxes, all have responsibility for the management and delivery of health services.

The control given to localise services within their own budgets – such as the Barnett formula in Scotland – has further propelled the diffusion of power to the national assemblies, where the focus can be targeted towards health issues that are more acute in that country. Such change has now led to the familiar analogy of “living laboratories” in each of the countries.

Distancing Westminster

Clear movement away from Westminster has manifested itself perhaps most clearly in Scotland, a country previously dubbed the “sick man” of Europe. Here the UK-wide quasi-market model of the 1990s has

been replaced by a cohesive system of integration across sectors, such as the recent development of Managed Clinical

Networks (MCNs) and Community Health Partnerships (CHPs). Such an initiative seeks to reduce inequalities in health and provision, while reflecting a strategy that aims to appeal to the electorate by connecting with key stakeholders, including the public, to drive up the quality of services.

Perhaps the most symbolic decision so far has been The Community Care and Health (Scotland) Act 2002, which granted free nursing and personal care, despite Westminster opposition.

Gaining confidence

This landmark policy marked the beginning of real devolution by demonstrating that Scotland was going to use its power to branch into contentious new waters. National plans such as the white paper in 2003, *Partnership for Care*, further indicated the widening gulf between the English and Scottish health systems by announcing the decision to eradicate the remaining NHS trusts. In this “laboratory”, citizenship and engagement has very much been at the forefront of driving a new model, which chooses collaboration over competition.

Neither has Wales shied away from new responsibilities. Faced with immense challenges, the country sought to move beyond its poor health status with bold strategy. A twin-track approach – focusing on preventing ill-health as well as accessibility to acute care – is similarly centred on collaboration and co-

29 January 2007

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operation. By seeking to build public health through partnerships and working across sectors between local health providers, government and communities, the country's national initiative, Health Challenge Wales, has made inroads in many areas previously neglected.



In contrast, England is one country where policy-makers have taken forward a more controversial NHS transformation. In the last decade particularly, a consumer-style sector has been carved out with emphasis on targets such as waiting times, increasing capacity and sharper market-style incentives. The implementation of foundation trusts, primary care commissioning and the use of the private sector in provision of services has led the country further down this road.

Yet, such a departure from traditional values of professional trust, arguably the foundation of the NHS in its early days, has not come without resistance. Acceleration of the choice and competition agenda in recent years has increased the furore and complaints of privatisation and fragmentation continue to plague Westminster. At the same time though, political figures remind us that waiting times have fallen and insist that choice is necessary to sustain the NHS and drive up standards.

Northern Ireland's short-lived regional assembly has had less opportunity to move towards an independent health policy. The suspension in October 2002 has meant that developments have until recently been stalled by political uncertainty, although elections in March give the country another opportunity to concentrate on a "best fit" healthcare model appropriate to the needs of its own citizens. How radical this is likely to be is still to be seen.

The challenges are varied. All countries are confronted with increasingly familiar problems. As the NHS ages so does our population, and the cost of care is likely to continue to rise. Such change in demographics and level of morbidity, countered with increasing expectations of

New Statesman/Pfizer policy summit

This summit brought together around 30 senior healthcare policy-makers and experts to discuss the impact of devolution on health policy and practice across the UK.

Six years after devolution, the four countries have developed increasingly divergent health policies. Policy-makers were asked to consider the drivers that have shaped these divergent policy directions; the impact they are having on public health and health service performance; and the big healthcare questions for each country – and the UK as a whole. Did they consider that the right steps are underway to meet our needs? If not, what should we be doing?

The summit was divided into three sessions:

Session 1

This session was intended to set the scene, looking at the factors that have shaped each of the four nations' health policies – politics, culture, population health priorities, infrastructure legacies and so on – and to look at their impact on health service and public health strategy.

Session 2

This session discussed the impact that devolution has had on the ability of healthcare providers to innovate on the ground, with a focus on health inequalities.

Preventing and treating major disease areas where there are greatest health

inequalities, for example, diabetes and coronary heart disease, are major chronic challenges for all devolved administrations. Indeed, Scotland, famously, has some of the worst health inequalities in Western Europe. The integrated approach necessary to change those inequalities spans both health promotion and treatment. In this way, the participants look at how well each of the four countries are doing at changing the NHS from an "illness service" to a "health service".

Session 3

During this session, panellists take the long-term view, looking into the future and considering what further policy improvements will be required to achieve markedly improved population health and more efficient and effective health services in each country by 2018.

Some challenges are common to all four countries, such as balancing budgets in a NHS that is going through rapid change, and the problems arising in populations that are living longer and have higher rates of chronic disease.

Increasingly divergent healthcare policy priorities may lead, effectively, to a country level postcode lottery across the UK for the provision of different services. In turn, this will lead to increasing pressure to reverse these policies. Will those devolved administrations (most likely to be Wales and Scotland) be able to hold their course?

patients and the potential problems in the logistics of applying new technologies, are but a few issues likely to threaten our "British" healthcare system with increasing tenacity in years to come.

The crunch point

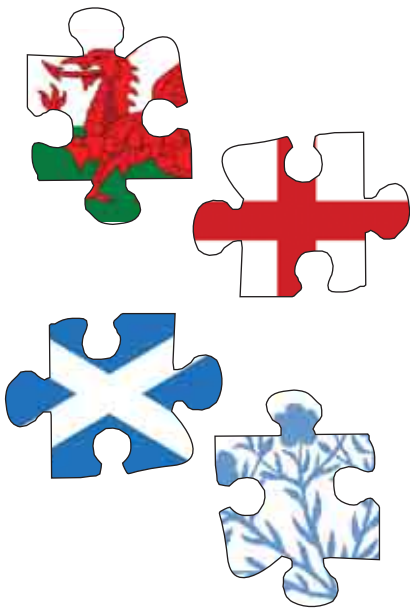
At the same time, with divergence comes regional inequality. Work done to counter this is in operation in all regions. The ban on smoking in the workplace, trail-blazed in Scotland, is subsequently taking effect across England and Wales in 2007. Other policies implemented in one country

might not be so easily applicable, or affordable, in the future.

Divergence has, so far, had a relatively easy run. With a Labour majority in each region, extreme political divergence was always unlikely. But after a decade in power, Labour control will be challenged and devolved governments will be emboldened by their successes. A new regional government eager to demonstrate its prowess may well wish to strike out in new directions, threatening the peaceful coexistence of current devolved systems.

Opening address

First Minister of Wales, Rhodri Morgan addresses the summit ahead of the sessions and details the policy approach that has been taken in Wales



Bill Clinton's devolutionary argument for having 50 separate states in the US, with their own distinct policies, is that it gave you 50 "living laboratories". My aim this morning as First Minister of one of the four living laboratories in the UK is to outline our twin-track approach to health policy and health services.

The sharp divide between the top and bottom of the unitary authority league for life expectancy within Wales, the two neighbouring authorities of Blaenau Gwent and Monmouthshire, shows two totally different industrial and social histories. You can see that same sharp contrast across the South Wales valleys and most of the rest of Wales, matching very closely the socio-economic group map of Wales – Wales has a much smaller proportion of its population in the middle class than either England or Scotland.

According to the Chartered Institute of Environmental Health, of the nine local authorities across England and Wales with the highest rates of reported poor health, seven are in Wales. Astonishing, given that the population of Wales is less than one-twentieth of that of England.

Practical actions

I can only touch this morning on a few practical actions. They include our funding to change inequalities in health, supporting 62 projects, bringing a focus on cardiac care to parts of Wales which have had inadequate provision. Our partnership with the Citizens' Advice Bureau, Better Advice/Better Health, provides financial advice in GPs' surgeries. GPs report it as enabling more people to access healthcare, reducing health inequalities, and enabling patients to



access non-medical advice. All this is in addition to putting millions of pounds in the pockets of some of the most disadvantaged families in Wales.

Our equity and advocacy grants are to help professionals identify wider social, economic or environmental factors affecting patient health, and so develop the stimulation of new local action to improve health outside the usual remit.

Our Food and Fitness Programme, is finding new ways to bring fresh food to disadvantaged communities, for example, working alongside community food co-operatives in the poorest wards in Wales.

These grassroots initiatives are drawn together by action at an all-Wales level under Health Challenge Wales. This is our major programme for harnessing the interest and commitment of services and citizens, of private and public interests, in improving the health of the nation.

The achievements of the Welsh NHS

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during our second term in providing timely and accessible treatment to those who need it have been remarkable. Three years ago there were 5,500 patients waiting more than 18 months for inpatient or day case treatment. Today there are none. Three years ago there were more than 12,000 patients waiting more than 12 months. Today there are none. There are no outpatients in Wales waiting 18 months for an appointment. There are over 10,000 fewer people waiting more than 12 months than a year ago, and we are on track to have no patient waiting more than eight months for either inpatient or outpatient treatments by the end of March.

Inverse care law

You will be familiar with Julian Tudor Hart's inverse care law: "The availability of good medical care tends to vary inversely with the need for it in the population served. This inverse care law operates more completely where medical care is most exposed to market forces and less so where such exposure is reduced. The market distribution of medical care is a primitive and historically outdated social form and any return to it would further exaggerate the maldistribution of medical resources."

Two things flow from the inverse care law as far as our approach is concerned. When it comes to allocating healthcare, our preference is for collaboration, not a reliance on market or competitive mechanisms. When it comes to provision of services, from buildings to hiring staff, we have a positive preference for building capacity within the health service itself, rather than relying on providers outside it.

Our preference for co-operation is at the heart of the design of our local health

boards, deliberately co-terminous with local authorities, with the responsibilities they exercise for improving the underlying causes of ill health and bringing together around the same table the whole range of players that provide and use primary care. The same basic principle has underpinned our Second Offer Scheme, where we identify the individual waiting patient likely to breach the waiting times limit and we make a second offer of treatment elsewhere.

Building capacity

Our approach to health is to build the capacity of our own services rather than buying them in from outside. Perhaps the best news about the Second Offer Scheme is that we will soon have no further need for it and will be able to meet our maximum waiting times.

We have invested heavily in training more doctors, nurses and allied professions, to meet the needs of our population. The first year intake into medical schools in Wales has shot up from 190, at the time of devolution, to 408.

On buildings, our position on private finance initiative (PFI) is pragmatic. We have used it where it serves the public interest. In general, calculations favour direct provision by public capital. Those facilities are run wholly and entirely within the Welsh NHS, for the benefit of patients with no other interests to satisfy in servicing PFI contracts over the next 25 years or in contributing to the profits of companies set up to meet that purpose.

You have a long day of debate and discussion ahead of you. I hope I have offered you a taste of the way we have been discharging those responsibilities here in Wales. Thank you. Diolch yn fawr.

Policy in a nutshell

England: New Labour came to power committed to abolishing the internal market, but has now come full circle and is implementing a more radical version of it. The dominant political emphasis is of the NHS as a self-serving institution. Policy aims to expose the NHS to patient pressure by forcing providers to compete for referrals, based on the view that a more responsive, "patient centred" service will occur.

Scotland: In the last five years, policy in Scotland has been heavily influenced by its professionals-based policy community. Scotland's priority is to create an integrated health system with close connections between components (rather than competition between them). The aim is to centralise specialist services and increase the community delivery of others.

Wales: In Wales, much more than in England or Scotland, policy is concerned with health rather than healthcare and there is greater emphasis on public health. Consequently, Wales has shifted focus away from maximum productivity of health services, towards changing the social determinants of health and integrating democratic politics and community to the health system.

Northern Ireland: Since the Northern Ireland Assembly was suspended in 2002, responsibility for health has rested with the Northern Ireland Office. With political inertia, NI policy has changed little since 1998. The future direction is expected to contain elements of Scottish redesign, Welsh localism, and English devolved commissioning.

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1. Devolution & healthcare

This session considered the respective policy contexts that have shaped healthcare devolution in each of the four countries, and the emerging outcomes. The discussion centred around the different models: the competition and choice model that has been vigorously adopted in England and the model of consensus and collaboration being taken forward by the celtic nations. What follows are the edited highlights of the discussions

Phil Parry I would like to start with each of the panellist giving us their standpoint and then I will open it up to us all.

Scott Greer There are three things that make the UK distinctive and do a lot to shape health policy divergence. The first is that the UK has, by international standards, an extraordinarily, permissive system in terms of policy. The Barnett Formula is not just a block grant that keeps Westminster and Whitehall from intervening in devolved policies. It also shelters any devolved government from the economic consequences of its policies, so that is extremely liberating.

This machine is, however, fragile. It is premised on the Labour Party always being in government.

There were distinctive policy communities before devolution. They have become more so. The assumptive worlds of policy-makers, as we will discover today, can be very, very different. The amount of communication is often less than you might think.

The other reason for change is simple party systems. The Labour Party is the only fully fledged UK-wide party with a chance at government. The Conservatives

are, essentially, an English party still, despite improvements in Wales. That means that Labour faces very different problems in government across the United Kingdom.

In England, Labour faces the old Tory challenge of “You pay the tax, where is the operation? You pay the tax, where are the hospitals?” In Scotland there is much more pressure from the Scottish National Party, from two Parties, one of them falling, admittedly, on the left. You lose votes on the left, not on the right in Scotland. Likewise, by and large, you can lose votes on both sides in Wales but, probably, you can lose more votes on the left. What you do to stay in office in Edinburgh and Cardiff is not necessarily what you do to stay in office in London.

That means there are two things to keep an eye on in the future. One is simple political change. The other is inter-governmental conflict. That is something to watch out for. The UK has had a remarkable honeymoon where governments are not interfering with each other. That is going to end.

Julian Le Grand There are four ways to run health services. You can run them on

the basis of trust; so, basically, you trust the professionals. You can run it on the basis of mistrust, where you give professionals targets, performance management and so on. You can run it on the basis of voice, when you rely upon patients or the public to express their voices individually or collectively through their elected representatives, or you can do it through patient choice and competition.

In all four systems of healthcare, there are always elements of trust, usually elements of command and control and certainly elements of voice. Much debate is about balance. How much choice and competition, collaboration and trust?

We have “laboratories” in the UK, where we are trying different combinations of these. Wales is relying more heavily upon trust and collaborative ways of doing things and less upon choice and competition.

In England, on the other hand, we have tried all the routes. You could say that the 1948 settlement was all about trust. We tried that. I think there was a feeling that that had not worked. We then moved to a period of fairly heavy command and control. There was a feeling that that, too, had its problems. I think that targets are demoralising for professionals and demotivating. They stifle innovation and invention in the long run and encourage gaming and distortion of various kinds.

I think voice also has its problems. The middle classes are just much better at manipulating bureaucracies and systems to allocate services towards themselves.

So we have gone down a choice and competitive route, and probably rightly. Other countries in the UK have gone down different routes, and an interesting part of the debate today will be finding out how successful we think these different routes are.

What you do to stay in office in Edinburgh and Cardiff is not necessarily what you do to stay in office in London
Scott Greer



We have had to improve regulation. We have had to improve governance. We have had to improve financial control

Ann Lloyd



Ann Lloyd Despite the fact that the Welsh health service was, until devolution, governed along UK principles, the service had started to move quite differently by the time I returned here in 2001.

A cultural autonomy where services were not joined up one to another had started to predominate. We knew we had poor public health status, we knew we had continuing inequalities and that government had to redress those balances.

In 2001, *Improving Health in Wales* underlined the imperatives of public health and service improvement. The problems we face in trying to reform systems were clearly outlined by Derek Wanless when he came to advise in 2003.

We had a culture where change was awfully difficult. There were so many good services being provided that were unsung, and there were so many managers and their clinical teams frustrated by a lack of initiative to get ahead of the game and really provide an excellent quality service.

Health Challenge Wales, launched in 2004, has sparked the imagination of many communities to take a greater responsibility for their own health and wellbeing and our new chief medical officer is producing a new health strategy.

Design for Life, published in 2005, shows how we will try to achieve world-class health services in the next ten years. That has been accompanied by *Fulfil Lives* and *Support Communities*, a broad high-level strategy for social services. It will be followed, in 2007, by tertiary care services.

We have also tried to tinker with how we allocate resources. With the new Welsh Health Survey we are revising how we are going to apply that funding formula more fundamentally. We have

had to improve regulation. We have had to improve governance. We have had to improve financial control.

On we go to our next stage, citizen engagement. Beecham has just reported on *Beyond Boundaries* to look at how we join up public service more fundamentally within Wales.

Colin Cook I am part of the Scottish and UK Civil Services. Professor David Kerr and his team produced a document called *The National Framework for Service Change*. Then the Executive responded to that with its own strategy document called, *Delivering for Health*, a sort of seven- to-ten-year strategy for healthcare in Scotland based on a model of providing services as locally as possible, as quickly as possible and as equitably as possible within our communities.

We have very strong pockets of deprivation, particularly in Glasgow, and there are separate responses in local communities to those kinds of issues. One in five people in Scotland lives in what we would classify as a remote or rural area and that has implications for the balance of things like choice and competition.

In Scotland, there is a strong social support for public service values and the values of the NHS. It is also about jobs and the sense of local community and local economy, and all those kinds of things.

The *Delivering for Health* response model of healthcare talks about being embedded in community and that the role of government and the role of the Executive is to facilitate that involvement of the community.

It has also been done by some things that attempted to facilitate the role of the voluntary sector and there is also a very

strong collaborative driver. Many members of the first parliament had a background in local politics and have a very acute sense of what is happening on the ground.

Finally, I think a driver would be that of citizenship, of the voice within the formulation of services. We saw that through the original Kerr process, through the decision to ban smoking in public places in Scotland, when 57,000 people chose to participate in a consultation.

Andrew McCormick In Northern Ireland, we have had uncertainty for many years and part of that has serious consequences for the effectiveness and working of policy. We had two-and-a-half years of devolution when some key decisions were actually taken. Of course, we are working in the context of a very divided society.

Following the suspension of devolution in 2002, there has been little reorganisation. More recently, as the difficulty of restoring devolution has been so acute, the tactic from the ministerial team has been to say, "Well, we'll get on and take the decisions and govern actively," and that has been very significant. We have a structure that is still based on the old 1990s context, with four boards as commissioners and 18 trusts as providers. That is currently being reorganised fundamentally.

Some important pieces of strategy did come out of devolution. *Investing for Health* had a very strong public health emphasis, echoing some of the points from Wales and Scotland, even though the final decisions were only taken after suspension of devolution.

At the end of 2003, we had the highest level of resourcing and the poorest performance of any of the health systems. John Appleby came in to do a review, commissioned by Paul Murphy and Paul Boateng as the chief secretary at that time, and that has led a lot of the debate and decisions that are currently quite active.

We are going through a fundamental restructuring, retaining an organisational separation of commissioning and providing, and simplifying the provider-side organisation, trying to introduce an element of local and community-based involvement through the commissioning system.

So, a lot of what is happening at the moment is actually a consequence of not

being devolved. To what extent the changes that are being taken go forward and what will be the decision-making process at an Executive level and an Assembly level depends on sufficient consensus and support at a political level.

So, a fascinating set of changes and who knows what for the next few months.

Phil Parry Professor Le Grand, why do you think it is that professionals are trusted in some parts and not trusted or trusted less in other parts of the UK? At least they are viewed as knights and knaves, I should say.

Julian Le Grand I think the truth is that everybody is actually a mixture of knight and knave; it may be to do with the scale of society. If you are going to run a health system on the basis of trust and collaboration, the presumption is that all the people working within it are going to work in the interests of the public good. So, a hospital that has an A&E department that is threatened by closure will not consider its own institutional self-interest or, in doing so, it will try to look at the more general public good and say, "Yes, okay, maybe our A&E department ought to close." It seems to me it is probably easier to work in that kind of system in smaller societies than it is in larger ones.

Julian Tudor Hart I think one thing we would all agree is that markets are driven by a search for profit. So, it is not an ethical question, it is an economic question.

Scott Greer England is unique and English Labour's problems are to its left, which means that there is a lot of good reason to talk of clear red water and to

"Choice" has been used to represent economic choice as understood by economists, employers and politicians
Julian Tudor Hart



quote the inverse care legal code in full. When we are talking about harnessing competition, an English acute trust chief executive is as fiercely competitive as anybody you are ever going to meet.

For the Scots, David Kerr is extremely good on how you can harness competition among the professionals. There is a structural divide between smaller and larger societies.

The question is whether you try to use policy to build a machine that will go on its own. In England, if you get payment by results and other things right, you will get the necessary reconfigurations. Or, you can do what they have done in Northern Ireland and Scotland, which is to come up with a strategy and say, "That concrete hospital goes, that concrete hospital stays."

Phil Parry In Wales, in relation to renewing and reorganising, we are seeing quite a lot of local protest at proposals in relation to reorganising services, such as closing hospitals.

Ann Lloyd What I think we have failed to do is to describe and show the alternatives. The building itself is a representation of something that was achieved by the community. So there is a mourning and attachment to a building, irrespective of the service. There are people who have managed to change their services fundamentally and they have had to work really hard to engage that population effectively. Over the next year, if we do not get that engagement right, some services are just going to crash.

Audrey Birt I think we see the same things in Scotland. I would say it is about involving

people from the beginning in that discussion, it is about them feeling that they are shaping the future alongside partners.

Martin Rathfelder I am from the Socialist Health Association. A lot of the policy debates in England are conducted by people who live, work and never seem to leave Westminster. Has it been possible for "smaller countries" to deliver the public health agenda? In England, every year, when resources are allocated to public health, they are subsequently sacrificed on the altar of deficits in acute care.

Ann Lloyd The public health monies have not been scooped up anywhere. They have stayed where they are. We will not solve healthcare in the future unless we can engage people better in protecting their own health. The Welsh Assembly government has been really focused on children in Wales having a much better future than their parents. It takes years to get there. But we have got to work to sort out public health. All the partners, like the general practice communities, are being urged to take that part of the agenda very seriously to ensure a healthier community on which to build.

Julian Tudor Hart For patients, choice is very rarely about "Do I want to go to this hospital, or to that hospital?" It is very much about their personal experience of whether somebody actually listens to them or talks to them in a language that is human.

Where relationships break down for whatever reason, for instance within GP partnerships, there should be arrangements for people to move over to somebody else, and not just be left to the discretion of different GP partnerships. In reality, "choice" has been used to represent economic choice as understood by economists, employers and politicians, but not as understood by patients.

So when you ask patients, "Is choice important to you or not?", you will always get the answer that it is important, but what kind of choices are you talking about?

Tony Calland I am a GP and my practice is in the Wye Valley, so 52 per cent of my patients are in Wales and 48 per cent are in

We deal with 84 per cent of those patients in general practice. But many policies are infringing more and more on primary care
Helen Herbert



the Forest of Dean in England. So I, daily, observe the differences between the two systems. I am a strong supporter of what the First Minister said about the design of the health service in Wales. It is an inclusive social healthcare model, without using alternative providers, as is happening in England.

My English patients are referred to Gloucester Foundation Hospital, a foundation trust that is extremely successful. It has hoovered up everyone with a disease within a 50-mile radius of the hospital. Health in Gloucestershire has improved astronomically but the trust has bankrupted the three PCTs that support it because it has over-performed. The effect is closure of community hospitals, services for and the elderly, and psychiatric services for the mentally ill.

The English competition model works to do easy surgical things that hit political targets but it distorts the market by concentrating on one section of the population that has conditions but which is not necessarily ill. The vulnerable areas of society (the elderly, the mentally ill and, to some degree, children with learning disabilities) lose out because it is not politically sexy to deal with them.

Colin Cook In Scotland, we have been able to generate a huge momentum behind the public health debate. Interestingly, however, where there is a political debate, it is the application of the principles, rather than the principles themselves that underpin our approach to healthcare.

Andrew McCormick We are all in this triangle of constraint between performance, equality and resources. We

are seeking to try to ensure that the financial regime we are working under – we do not have payment by results – is suitable for our context, that it puts the resources in the hands of the commissioners whose mission is public health driven.

Scott Greer There is a sense in which command and control is greatly envied by people who want to sell policies around the world. Choice is not a real political winner. It is a device to improve efficiency and so forth.

People use choice but they will not necessarily vote on it. It is a hard sell for the political parties but, because your average NHS trust runs on such a small margin of error, if they lose 4 per cent of their patients to somewhere down the road, it is a real crisis for them. So there is an extent to which, even if nobody wants it, there is a case to be made for choice.

Helen Herbert I am a grassroots GP working on the west coast of Wales.

GPs are very proud that, as a profession, the public trusts them more than all the professions. Our traditional values are advocacy; longitudinal care; access and we have generalist skills. You need broad thinking about all the issues.

There are 259 million GP consultations a year. We refer only 16 per cent of them. That means that we deal with 84 per cent of those patients in general practice. However, many policies are infringing more and more on primary care.

We were asked to comment on the Consultation on Acute Services in Wales, obviously secondary-care orientated. However, primary care and social care have huge implications and this really was

not recognised within that document at a strategic level.

Elizabeth Mitchell I am from the Department of Health in Belfast. What we have done also shows that the professionals that patients trust are the GPs and health visitors. Within our new arrangements in Northern Ireland, we are tying that into our local commissioning, which will have a strong primary care focus.

David Ford A choice model depends on good quality, relevant information to inform a choice. It strikes me that the NHS has been very bad at counting and measuring things.

Julian Le Grand I think one of the good by-products of the choice agenda is the pressure it puts on the NHS to provide information so that people can make informed and sensible choices. Heart surgeons are now producing mortality rates for each surgeon. One of the things about the very successful choice pilots in England was that we had patient choice advisers who were very successful on giving useful information. The importance of actually giving advice and making sure that it is not just a simple consumerist choice, but a considered choice, is being emphasised.

Phil Parry To tie this up, is it fair to say that England has looked at choice far more and has trusted the patient more than the professional and that it looks as though Wales, Scotland and Northern Ireland as well, are going down a different route where choice may not be so widely accepted?

Julian Le Grand There is a greater degree of reliance on empowering the patient through the mechanism of choice in England than there is in other parts of the UK.

Audrey Birt I would say that the stress is on information. I think you said it is informed choice. It is about information and education, that is when people make the right choices in terms of their healthcare.

Phil Parry Thank you all. We will be looking at how that delivers in relation to tackling inequality after the break.

2. Innovation & inequality

This session looks at inequalities in health and healthcare, mostly in relation to Wales, Scotland, and Northern Ireland. It examines how devolution is addressing inequalities and whether it is succeeding or not. Panellists also consider the effect that devolution has had on allowing healthcare professionals and policy-makers to be innovative in finding solutions to tackle these inequalities

Phil Parry I am going to offer you a few minutes to explain how you think inequalities can be addressed, what can be done, especially in long-term care.

Audrey Birt We have looked at the voice of people with diabetes in Scotland and asked them about how diabetes care changed since the publication of the framework for diabetes. One question was, “If you could change one thing about your diabetes care what would it be?” The answer we got was, “It is to make myself understood.” One of the key things we have to remember is that it is about hearing the voice of the people. I would argue that, within the devolved nations we are closer to hearing that voice.

We identified a lack of provision for people living with depression and diabetes. We were able to develop a leaflet to meet their needs.

The other voice we have given is to young people. People from minority ethnic backgrounds have less access to healthcare than wider sections of the community. The same is true for young people. We see only about 10 per cent of young people with diabetes meeting the NICE criteria for good care outcomes. We

engaged with them in a different way, heard their voice and are bringing that back into the healthcare agenda.

The Long Term Conditions Alliance strapline is “People not Patients”. It is about people living with long-term conditions. Most of the time they are people living their lives and they want support and encouragement to be able to do that.

This slide [indicates picture] is of a conference on self-management. The person addressing it there is Angela Donaldson, director of Arthritis Care in Scotland. She spoke about how she was told by a GP 22 years ago that, because of her rheumatoid arthritis, she would no longer be able to work at all.

What we mean by a person-centred strategy is somebody who is empowered to make decisions about their own healthcare, who is not a passive recipient of care with learned helplessness.

We see huge inequalities in the access to healthcare within Scotland in some of the remote and rural areas. Scotland has the potential to lead the way in things like telehealth and telemedicine because people with long-term conditions very rarely need the laying on of hands but need

access at times to specialists to give advice.

We need to develop healthcare that reflects the differences in our culture. I think that devolution is allowing us to do that.

Anne-Marie Telford First of all, in terms of services, in 2001 the Northern Ireland Assembly decided that it would create an executive programme fund by top-slicing the budgets of all government departments. The fund was to promote innovation and improvement in services and in policy, targeted where there was greatest need. The sub-plot was that this would also be a nice mechanism to get ministers to work together who were used to working down in their own political silos, so it would hit lots of buttons.

Just one of those successful bids to the fund which has made an enormous difference to the lives of disabled children and their families, called Wraparound, gained £1.5m of funding over a three-year period. It came out of listening to the parents of young disabled children, who told of disjointed services, of lack of support, and lack of respite. Through the Wraparound project, we set up a parents’ forum and a young people’s forum. We developed and redesigned services and brought together teams of professional staff so parents could get all their child’s assessments done on one day. We set up these teams in a local setting. We expanded and improved respite facilities. Recently, we have developed a fast-track card to give to the parents of the most profoundly disabled children, in case they have to go to A&E. Parents feel empowered, better informed and have peer support. The children are more confident, have more friends and new skills.

On strategy, Andrew McCormick mentioned this morning our public health strategy, *Investing for Health*, launched in

When Peter Hain published an anti-poverty and social inclusion strategy, it was the first ever in Northern Ireland
Anne-Marie Telford



Wales is quite open to innovation because it is “small government”
Ronan Lyons



2000 to tackle inequalities. It set achievable goals, narrowing those gaps and the mechanism to do that. Six years on, that strategy is alive and well. There are *Investing for Health* partnerships working across Northern Ireland led by the four boards, tackling issues identified by the community and addressed in partnership with the community – issues like food poverty, fuel poverty, the needs of the traveller communities and ethnic minority groups.

We were delighted when just last month, Peter Hain published an anti-poverty and social inclusion strategy, the first anti-poverty strategy we have ever had in Northern Ireland.

My final example is about a scheme that is simple, straightforward, and was brought in overnight. It was bringing in the free bus pass and train pass for older people, in March 2002. It gets older people out and about, gives them their independence and keeps them physically active.

Ronan Lyons When you look at the continuum from “could do something” to “will do something” to “doing”, the only thing that counts in the end is the “doing”. I have been privileged to be involved in a piece of work called *Combating Child Poverty in Wales – Measuring Success*. It outlines the whole approach across the Welsh Assembly government to reducing inequalities, including health inequalities. That was a piece of work which we helped to produce in the National Public Health Service and it is part of the university. It sets out a whole list of targets and milestones to achieve.

Wales is quite open to innovation because it is “small government”. That is a feature right across Welsh life and across

small governments. It probably happens in Scotland to a good degree, and I imagine in Northern Ireland, but I am sure it never happens in England.

Another aspect is that, actually, we are better informed on scale and distribution of health inequalities and the consequences to Wales. We have here in Wales a unified National Public Health Service, which does not exist anywhere else. Because of that, the service has better capacity to actually deliver on the ground.

The one area where we are not very strong is manpower. The number of bums and brains on seats is below par for other parts of the UK, but it punches above its weight because of good service organisation.

With the development of the Health Information Research Unit, one of the things we are doing is developing methodologies by linking anonymised data sets at the individual level right across community care, primary care to secondary care, linking with local authority data.

Many of the problems that we look at with health inequalities are actually quite complex problems. Only looking at them in one aspect hides so much.

We are also developing the capacity to deliver and evaluate public health improvement projects here in Wales. We are fortunate that the Wales Office of Research and Development has funded an infrastructure that will work towards our goals. One is the Health Information Research Unit. The other is the Public Health Improvement Research Network, which is an all-Wales network, led by Professor Lawrence Moore in Cardiff. That network that has been set up to evaluate complex interventions like policy interventions across health and social care.

When you put those things together we have the capacity to evaluate and inform policies in a much better way than exists anywhere else that I have seen in the world. It does take a bit of time but it is a more thinking government and contemplative way of working than just rushing to press the media button when launching programmes.

John Williams Sir Michael Marmot gave a lecture at the Royal College of Physicians in October, the Harveian Oration, where he outlined very lucidly the evidence for empowering people in order to reduce inequalities in health. You can do all you like to provide the services, but you have got to empower them to use them and to want to use them.

I chair a charity that is focused on groups that are not fully able to achieve full fitness and full health. How empowered do obese people feel to use a leisure centre where they stand out because of their obesity? What leisure centres have ramps down into the pools so that paraplegics can get into them and use them?

Anna Donald I am the chief executive of Bazian, a company that produces systematic reviews to help people assess technologies, procedures and public health programmes. The evidence base for a lot of things that you might want to do changes all the time and countries are continuously doing useful experiments that we could all benefit from.

Wales has a very interesting joined-up working arrangement, which is unusual and also difficult to achieve in England. A lot of the interventions that work best are not health interventions but interventions in factories, in domestic architecture and things that need to be monitored by health visitors, for example, childhood accidents in the home, which is one of the biggest gradients. I am very interested to see whether Wales could lead the way in helping us understand better ways of working across sectors, because it is smaller and easier to get access to people in other sectors, although that, of course, has its own difficulties as well.

Ronan Lyons One of the things we have here in Wales, is the Collaboration for Accident Prevention and Injuries Control (CAPIC), funded by the Welsh Assembly

The fifth wave of public health policy...is quite a challenging concept for the evidence-based medicine approach

Audrey Birt



government. We keep all practitioners updated of systematic reviews and injury prevention, all available on a searchable database.

The other really good bit about Wales, which I did not bring up, is the co-terminosity between health boards and local strategic partnerships, and that is so much easier because they match up and they do not have a three-to-one or a two-to-one or any other funny relationship.

Phil Parry There are an awful lot of them – 22 – and some of them are very small.

June Clark My professional background is that I am a community nurse. I wanted to raise and make explicit the usefulness of information and communications technologies (ICT) in facilitating self-management in tackling chronic diseases, improving access and reducing inequalities for isolated individuals and remote communities.

This week the Royal Society is about to publish its report on the impact of ICT on health and healthcare over the next ten years. It gives examples, such as enabling young diabetics not only to monitor their own blood sugar and not only to give that information to a carer so that they can get specialist advice back, but also to get immediately on their mobile phones pre-programmed variable advice according to what their blood sugar reading is. I think the work of that kind will make huge advances in people's ability to manage their own affairs.

We have four fantastically different ways of introducing ICT in the four countries of the UK. Everybody knows about England and the bad press that Connecting for Health gets. In Wales,

Informing Healthcare is doing much better. Scotland has a third way and has gone even further, even faster.

Ceri Phillips We have heard from a number of speakers about the relevance of evaluation and the way it is now beginning to inform policy but, unfortunately, politicians are not the best users of evaluation. We get vast investment in evidence relating to effectiveness. We get NICE and all of those medicine strategy groups, including the Scottish Medicines Consortium, looking at efficiency. We do not, however, have that handle on health inequalities. We are still hamstrung by the infrastructure and organisational frameworks that do not necessarily enable us to look at health inequalities from a serious perspective.

Tony Calland I want to refer to the tension between central policy direction and local policy direction. In Wales, because we have got 22 local health boards, we have, in effect, 22 different implementation methods. That causes a degree of inequality of service provision to different parts of the community.

Local accountability may be very good for group A in Merthyr, or group B in Monmouth, but they may not be very good for the opposite groups. The whole thing is a tension about how you actually balance healthcare. The more you divert it down to local government and local authorities, the more you run the risk of generating a sub-set of inequality.

Scott Greer There has been a lot of international research about the optimal size of health units for various tasks and

the kind of high-five figures you find in a lot of local health boards (LHBs) is optimal for local engagement that involves knowing about the society. It stinks for some other purposes.

The problem is that you would end up with about ten levels of local government and health commissioning units if you tried to be the most efficient – try explaining that to a minister.

Anne-Marie Telford I think it is a trade-off. We are moving from having four boards and 18 trusts to having one regional authority and five trusts. I think that will allow us to have a much more even distribution in terms of how policies are implemented. The size of the units at the big level are already decided. There is a lot of debate going on in relation to how that gets carved up below that level into the unit size.

Phil Parry Audrey, your key message was empowerment and voice. Is that a central plank in relation to Scottish policies and does that address the inequality issue?

Audrey Birt One of the speakers at a self-management conference a couple of weeks ago was Professor Phil Hanlon, who set up the Public Health Institute in Scotland. He spoke about the fifth wave of public health policy.

The fourth wave was at a time when I was studying public health myself, it was looking at the NICE approach and the standards and systems approaches to public health.

He spoke about the fifth way as being the mobilisation of a resource. It was about showing how people engage with each other and it is about how we engage as clinicians and in roles like my own. It is quite a challenging concept for the evidence-based medicine approach.

My challenge would be to ensure that that fifth wave is in there. How do we integrate it in there and how do we make it a fundamental part of healthcare? I am sure that most of the people in this room who came to work in healthcare came because they wanted to make a difference for individuals. That is what motivated them.

Phil Parry Thank you. After the break, we will look ahead to the next 20 years.

3. Long-term devolved care

In this session, participants look ahead and consider what health policy will look like in their countries in 20 years' time. Panellists consider what further policy improvements are required to achieve markedly improved population health and more efficient and effective health services in each country. The session ends with a closing speech on the summit from Welsh health minister Brian Gibbons

Phil Parry We are going to look ahead now to where we are going to be in 20 years' time. Are we going to have addressed this whole issue of reorganising ourselves? Will we direct the money in the right way?

Tony Beddow The first challenge for population health in Wales and elsewhere is the impact of alcohol. It will be good if Wales can act as a laboratory for the rest of the UK in dealing with it. The second is an understanding of the application of the concepts of social cohesion or social capital. In Wales we have a lost a lot of the things that created that social cohesion and capital. Third, if our present range of antibiotics runs out, we will have a new paradigm of infectious diseases to deal with. We need to become better at reducing the lead time between proven innovation and mainstreaming that innovation in our healthcare services.

On systems, if we are building partnerships, should we not build into that performance management measures that reward good quality partnerships?

Redefining boundaries of primary, secondary, and community care is essential. We have to redesign services to

be user friendly for older people.

About 35 per cent of medical staff in Wales are not trained or born in Wales. We have a marketing job to do on that.

Policy, management and professionals are inherently in conflict because their value bases, timescales and loyalties are different. With devolution, we have an electoral cycle that effectively operates every two years, because the Welsh and national UK elections operate at two-year intervals. That is a recipe for paralysis that requires the political process to produce a stable policy environment with which the professions and managers can engage.

We must find a better way of using information technology to link services across delivery agencies and that includes patient-held, patient-used, and patient-modified records. We also seek to set automatic measures to guide and shape good clinical and professional practice.

Colin Cook In Scotland, the model set out for delivering for healthcare is more or less the model we will be working towards for the next ten years. We have heard about the integration with the voluntary sector.

We are doing some interesting things on

how workplaces can get involved in promoting the health of staff. Then there is this critical element in *Delivering for Health* about the future model of care, with patients and carers as partners. Our next challenge is to use data on patient needs to influence services. Technology is opening up opportunities to empower individuals in their homes and communities.

On health inequalities, most administrations are focused on smoking as the first key challenge and clearly there have been huge strides. Alcohol will be a big political agenda in May. There is diet and physical activity, as well as mental health. From the pilots I have seen in places like Lanarkshire, interest and engagement of the population is extremely high but we have a long way to go to prove it has an impact on health.

Barbary Cook The Community Development Health Network is a membership organisation that works with communities across Northern Ireland to tackle health inequalities through community development. My own health cannot be divided from the health of my neighbour, so, when we look forward into the future, with the return of devolution, one of the main public health strategies would be *Investing for Health*. Another political party might not have the same politics but there would be a shared set of social and political values around fairly neo-liberal economic policies. More and more political parties are expanding their policy division, so that is a good thing.

We are aiming to expand the understanding of organisations on health inequalities. We have come up with the phraseology of communities as co-designers, co-commissioners, and co-providers of services. We are looking closely at the Scottish model.

If we are building partnerships, should we not build into that performance management measures that reward them?
Tony Beddow



There will be massive change around minority ethnicities in Northern Ireland and the changing demographic for that. That is a phenomenon north and south of the border, in a country that people always emigrated from but that now has massive immigration into it.

Jeremy Felvus We have not discussed today the economic imperative for health. Derek Wanless pointed out not only the costs of people being ill but also the benefits of them not being ill, in terms of contributing to our society. In healthcare, obviously we hear all about the current and future problems, but another way of looking at it is that health is an investment. This is the elephant in the room.

We have talked about all sorts of ways that we can spend the money we have got, but nobody has talked about the envelope of money we have, the mix of it and how we use it. Second, it is necessary to look at different ways of working and new partnerships. An example of how this might happen is that we are working with the East and North Birmingham PCT to implement a system of telephone coaching of people with high-risk cardiovascular disease and diabetes. That has had a tremendous effect.

Third, I agree with the other speakers that we need to mobilise the public; we need engagement at the individual level [in healthcare] that I do not think we push terribly well.

Owen Smith Another elephant in the room is divergence. The scale of change in England over the past couple of years means we do not really know what the overall impact on health outcomes will be

Nobody has talked about the envelope of money we have, the mix of it and how we use it
Jeremy Felvus



as a result of these system changes, but we know there will be divergences. Will empowerment mitigate some of the dissatisfaction that may arise from divergences in the services people end up being provided with?

Anthony Beddow We have always had a divergent system in the UK, which is why we have a vast range of inequalities.

Julian Tudor Hart The health service does not just deal with health. It is a stabiliser and creator of society. I am working on a pamphlet for the Bevan Foundation, proposing that, as Wales was the birthplace of the NHS and the birthplace of post-war British epidemiology, we should try to establish a Cochrane population. Cochrane is the inventor of quality population-based medical and social research. It would have to be sponsored by the Assembly but something like that could provide Wales with something as big, eventually, as the coal industry was in the past.

Andrew McCormick The imperative from a technocratic point of view is to drive through efficiency and productivity and promote public health because that is the only way we can see something that is financially sustainable in the long term.

John Williams All four countries are moving towards more care being delivered in the community, with greater patient involvement and empowerment. I hope in 20 years, we will see an eradication of the artificial interface between primary and secondary care, with those sectors working together, avoiding duplication of services.

Ceri Phillips What we have not seen in any government are creative ways of looking at resource allocation. Incentives derive from managing budgets rather than from managing patients. We have to look creatively at how we allocate resources to meet patients' needs.

Scott Greer There is a chance that something under the guise of "health policy" will wreck, if not the NHS, then the devolution settlement because we are seeing a lot of divergence and remarkably little connection on an intergovernmental level.

England is 25 per cent of the health systems in the UK but it is 85 per cent of the population of the electorate. If there is an intergovernmental clash, it won't be England that loses.

The new threat we have not talked about is that you are going to start tearing up parts of the devolution settlement regarding arguments about healthcare. Likewise, what is an appropriate waiting time for the EU? From the EU's point of view, the UK is the only place that can speak for the UK. There is no formal Welsh participation in the EU. Wales is going to have to lobby hard not to end up with a definition that excludes its democratic autonomous policy decisions.

Tony Beddow There is still a long way to go to bring the performance of the care system, and the hospital system, up to speed. Our financial procedures in Wales are distributive, not redistributive.

Helen Herbert In Wales we have a palliative care strategy that was published in 2003. It does not recognise the needs of end-of-life care. Patterns of diseases are changing but what will never change is that we need care in the dying phase. All four countries need an end-of-life care strategy to accommodate not only the terminal phase but also the chronic diseases that we have talked about today.

Jeremy Felvus We have to have a smoking ban in Wales. If we put more money into that we will have saved a huge chunk on health inequalities.

Owen Smith If you look at the way some of the Scandinavian countries have deployed smoking cessation policies, it has been through public private

The traditional role of the district general hospitals is becoming obsolete and we are looking at refashioning hospital health services

Brian Gibbons



partnerships, notably with some of the telecoms companies.

David Ford People are quite happy to put themselves in the hands of third parties to get curative services if they are confident that they are going to have low risk and good outcomes. But, when they want care, they want it locally, from people they know, with services they can rely on. We need to keep both things going.

Phil Parry Where do you think healthcare will be in 20 years' time?

Tony Beddow I would like a primary care service in Wales that continues to act as the patient's friend and guide in a more informed way and where the patient and the GP drive the other care processes.

Jeremy Felvus I would like to have a government that leads the debate on how we generate our investment in healthcare and how we spend it; a population that takes responsibility for its own health and a mixed economy where the mechanism is less important than the outcome.

Barbary Cook I would like to see public services designed coherently so the wider determinants of health could be worked on more effectively with communities.

Colin Cook In 20 years' time, I hope patients will be genuinely involved in the design and delivery of their care, supported in self-care by agencies and the system will be sufficiently flexible to respond to it regardless of some of the boundaries that we currently have.

Phil Parry Thank you to the panel. Our

closing speaker, is Welsh health minister, Brian Gibbons.

Brian Gibbons The healthcare we want to deliver in Wales has a clear Welsh focus. Obviously, the professional regulatory mechanism is on a UK basis. Much of the legislative opportunities we would have liked to pursue were not possible within the framework of the devolution settlement we have had up to now. However, being a small country does give us an easier opportunity to develop a sense of national purpose.

We cannot solve every problem on our own and we have, if you like, pinched some of the good ideas that exist in other countries. One of the big challenges we have is delivering efficiency targets to turn up the type of money needed to sustain the health service in Wales, given that we are not going to have the high-single-figure percentage increases in expenditure that we have had up to now.

As we developed our tenure strategy for health and social care, we looked at what was going on in Scotland and it was reassuring how much symmetry there was, both in our analysis of the situation and the direction in which we wanted to travel.

In launching *Design for Life* we wanted to indicate clearly that we were committed to modernising public services, delivered on the basis of need and free at the time of use. The move towards free prescriptions in Wales next April is an example of that commitment.

Derek Wanless did bring the message to us in Wales about how important health is in underpinning an effective social care system. Local government is where social services are based. One of the key statutory duties of local health boards and local authorities in Wales, on the back of

creating this new health structure, was their statutory requirement to produce health, social care and wellbeing strategies.

Wanless also sent a very important message to us as an assembly government. He said we were overdependent on the acute hospital sector and that this sector spread itself too thinly across Wales. The traditional role of the district general hospitals is becoming obsolete and we are looking at how hospital health services can be refashioned.

So, the key emphasis is on service reconfiguration. We have had to work across existing organisations because, if you start reorganising the administrative or organisational set up, you can say goodbye to two or three years of effective focused work. It has been a massive challenge for the health and social services in England and Wales to move to reconfigure services here in Wales. I think the necessity in Wales is probably more acute than in other parts of the UK because we do not have the generous Barnett Formula of Scotland, for example, but our health and social care and illness needs are so much greater than those in England.

The number of people in the Welsh Assembly is 60. A swing of two or three seats out of those 60 can have massive implications for the political balance of England and Wales. The political challenge of delivering service reconfiguration is much more complex and is more difficult at the political level here in Wales.

We think that our public services in Wales will be best delivered on the basis of partnership co-operation and collaboration, not commercialisation, competition, outsourcing and privatisation. We need to get our public services working more closely together with a shared responsibility for delivering care to the individual and to the community. I think that this approach is encapsulated very much in the title of our social care consultation document *Fulfilled Lives, Supportive Communities*. It is a distinctive model, based on Welsh values and needs, and the opportunity has been given to us by devolution to allow us to deliver it here in Wales. Thank you. *(Applause)*

Phil Parry Minister, thank you for the closing address. Thank you everyone for all your contributions today; it has been a fascinating debate.

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