

new statesman



A

2020

vision

for the NHS

**Special
Supplement**



Introduction On 15 April, the *New Statesman* and Pfizer hosted a round-table discussion on the future of Britain's national health service. As the election approaches, health, and the NHS in particular, will be in the forefront of people's minds. But what are the important issues, and will the NHS remain recognisable in 2020? Representatives from government, the UK healthcare sector and industry came together with policy advisers and commentators to consider how the health service can evolve to meet changing needs. Will choice become inevitable as we expect the health service to respond to our increasing consumer demands? Should we be concentrating less on choice and more on primary care in the community? And as we live longer, will we be healthier than ever before? This event was the first in a series of six policy forums, in which leading opinion-formers will debate the key policy issues that make an impact on the healthcare sector.

Participants



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About Pfizer: Pfizer is a research-based global pharmaceutical company with its UK business headquarters in Surrey and global headquarters in New York. Pfizer discovers, develops, manufactures and markets leading prescription medicines for humans and animals, and many of the world's best-known consumer treatments. It is the leading supplier of medicines to the NHS. Every month, more than two million patients in the UK are prescribed a Pfizer medicine.

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Round-table discussion



Margaret Mythen Welcome to this *New Statesman* and Pfizer policy forum: “A 2020 vision for the NHS”. Even though we are in the run-up to a general election, I want you to put aside campaigning and think ahead to the year 2020. What will society look like? Will there be a health service, and what will people expect and need from it?

Chai Patel Society as a whole will look older. And it will probably be richer, both in money and knowledge, though not necessarily wiser. There will probably be a far greater emphasis on genetics when it comes to how we procreate and how we deal with afflictions. If we look at the past century, especially at where our public services were, we had a notion of the public good on the issue of health. With commerce now a factor in how we deliver services, I think that public good will no longer be delivered by public services, but through a plurality of providers.

Polly Toynbee The NHS is currently at a crossroads, and it is not clear which way it will go. The people who have

constructed the system that is about to be let loose really don't have much idea about how it's going to change. What is clear is that strategic planning will become almost impossible, even from month to month. It's going to be more like running a supermarket where everything is much more hand to mouth, because if patients can choose where to go, you will not know how many patients you are going to get and therefore how much money you will have. The money will follow the patient.

There will be deliberate over-capacity, too. As John Reid has kept saying, to have choice you need over-capacity. The question is whether everyone will suddenly start choosing the private sector much more, and whether that will change the NHS into nothing but a service for emergencies and complicated and expensive cases. Reid confidently says that he cannot envisage more than 15 per cent opting for the private sector, but I cannot see any brakes on the system which would prevent that from happening.

This is a matter of lighting the blue touch paper to see what happens. It could be creative or it could be what's called “creative destruction”. The NHS has the most ►

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ways to get people to think differently about the NHS if we want it to survive.

Chris Grayling If you look at surveys of people's attitudes, the generation now in their thirties believe, want and expect an individualised service on demand. That is not simply health related. So you may be arguing the impossible, because for any politician of any party to change the attitudes of a generation is an ambitious goal.

John Hutton What our parents and grandparents wanted from the NHS was the peace of mind of it being

► passionate support of any organisation in the country. If any politician tries to lay a finger on it, they are in trouble. Yet expectations are galloping very far ahead of delivery, and people have two different models in their minds. On the one hand they feel it ought to be as good as it looks in the private sector brochures, but on the other hand there is an emotional commitment to the NHS, and these two views are at war with one another. To keep the NHS going, we have to remind people that they are not customers but citizens and co-owners, and that is why using the NHS is different to shopping in Tesco.

To keep the NHS going, we must tell people they are not customers, but citizens or co-owners

I also think there is a huge job to be done in educating people about what real health is. Real health happens in the community, and preventive medicine plays an extremely important role. Yet politics always centres on the area where politicians can manipulate the levers themselves. Politicians think they can run hospitals, but the messy stuff – the 90 per cent that happens in the community – never gets the attention it deserves, because everything is focused on surgery waiting lists. We have to find

free at the point of delivery. That is immensely important, and I do not think we should discount that. Inevitably, when I talk to my kids, it is something else, much closer to what Chris was saying. Listening to Polly, you could get the impression that we are trying to do things to the NHS in the UK that no other country has ever done in relation to publicly funded healthcare. That is simply not true. Prospective payment systems and the concept of choice are widely employed across publicly funded healthcare systems in Europe. Adopting those systems doesn't mean that we have to wave goodbye to the concept of a comprehensive, properly structured and properly delivered healthcare service. There are pitfalls, however, and we have to be careful to avoid them.

One thing that I think is certain about healthcare in Europe, and in all developed nations, is that the cost of providing the best-quality, most technologically advanced service to patients – which is what we want in the NHS – is going to rise. There will obviously be a significant difference between the cost of providing that service and the ability of most people to pay for it.

I think that the family values and principles of the NHS will look just as relevant in 2020 as they do today, because the alternative to a universal tax-funded system free at the point of use will be co-payment, pay-as-you-go and top-up vouchers, which could turn the NHS into a second-tier service for the poor. That is not an adequately ambitious vision for the future of public services.

What matters at the end of the day is that you get the best-quality care when you need it because you are sick and not because you have got personal wealth.

James Johnson It is almost exactly 20 years since I became a consultant, so I can look back and ask “Have things changed?” And they have, but not hugely. I still do operating lists, clinics and ward rounds. We can do more for patients now – keyhole surgery, for example, didn’t exist 20 years ago – but the basic shape has not changed much. From a personal point of view, the main difference is that we are now being shoehorned into doing a much narrower range of, in my case, general surgery. We are undoubtedly heading down the American route. If you want to have your platelets looked at, you have to go to a plateletologist rather than a general haematologist. That is a very expensive road to go down. You need a huge number of doctors to deal with every little sub-speciality.

An alternative road would take into account that an awful lot of healthcare can be delivered at a very general level by people who are not doctors or nurses. Much of the work we do, such as looking after people with asthma or diabetes in the community, can be done perfectly well by skilled workers in those fields. This is probably a decision that we have never formally thought about.

It would be a total disaster to go down the super-specialist road, but that doesn’t mean we’re not going to do it. The public seems to have been converted from the view that the NHS, because it is free at the point of use, must provide every service to being indifferent about who provides it. The staff of the NHS will take a lot more convincing, but I suspect that might be a fact of life three years down the line.

We also have to think about how we deal with the huge chunks of healthcare that the private sector isn’t interested in. No one wants to look after dementia, obstetrics or accident and emergency. We have to introduce non-state providers in some of these specialities, and no one has looked at this yet.

Litigation is also a terrible worry. In America, medicine is dominated by it, and the costs of medicine are driven by it. Whether you get offered an operation often depends on whether the surgeon is willing to take the risk that it might not work, and on whether his figures would plummet as a result. We are showing a tendency to go down that road.

Are we going to move largely to a blame-free culture where we learn from mistakes, or are we going to end up publishing lists of results that show who is the best and worst doctor? If we go for the latter, no one is going to be honest about mistakes or make any effort to learn from

them. There is a choice for us and I don’t think we have made up our minds about it yet.

Frances O’Grady There will be huge demographic changes by 2020: an ageing population, longer lifespans, fewer babies and more hip replacements. And I think there will be as much emphasis on social care as on crisis care. That raises the prospect of needing to look at a national health movement rather than just a national health system. I am optimistic that, by 2020, people will want a more sophisticated debate about choice. There is a big difference between people wanting choice over appointments in their local surgery and people wanting to get a subsidy for a private operation. The debate will have to be a lot smarter. There could well be growing disillusionment with the language of market solutions and consumerism.

I also wanted to highlight the issue of the workforce. There will be a million more workers, the majority of whom will be women. I suspect that many of those ►





The second basic dilemma is not particular to the health service, but is relevant to all big organisations. How do you achieve a balance between centralisation and decentralisation? I chair a small group on pulmonary hypertension – a specialised condition whose sufferers are crying out for central funding, otherwise they get lost in a decentralised system. How to balance centrally driven objectives and local management is very difficult.

John Hutton One thing that is reasonably clear is that the issue of choice is going to be more important on a personal

► women will be a good deal less patient about how they are treated at work and what opportunities they are given. We need to take into account the bigger picture that workers' expectations are not just about a job and decent pay, but about a much better quality of work experience. It is the workers who are motivated to deliver a better service. To harness that might be a more powerful lever for change than many of the other solutions currently being debated.

Vincent Cable Over a generation, we will face changes that are completely unexpected. If we look back at the early literature of the NHS, the underlying assumption was that health spending would fall because, as people got healthier, they would need less healthcare. That is a bizarre view, because things can change fundamentally.

The population is getting older and our demographic projections are probably about as solid as anything we can plan on. An awful lot depends on net immigration and that, in turn, depends on politics as well as economics. Given what we currently know, it seems there are two main dilemmas that will persist over the next 15 to 20 years. The first, already touched on, is how you reconcile within a public good a variety of choice. You could have choice by advertising services, but how do you get more sophisticated choice within a public service? For example, where do people die? Surveys have shown that most people want to die at home but, in fact, they die in hospitals or in some kind of institution. Where do women have their babies? Again, choices are not realised very often.

level. On the centre left, there has been a kind of snottiness about choice – it is a Tory thing, not for social democrats to be involved in. That is a huge mistake. We demand choice over who governs us, but we have not applied the concept more widely. Choice for our kids in the future will directly affect their views of citizenship. An informed and discerning population, which is what we will have in 20 years' time, will expect choice. What is the alternative? The alternative is a public sector organisation telling you where you have to go. That is hopeless. We are not going to build a consensus in support of the basic principle of universal patient care on the basis of no choice.

David Pink It is quite difficult to leap 15 years ahead. Probably 90 per cent of what we debate will be out of date in 20 years' time. Someone will read this discussion and say, "Did they really think that was an issue?"

Polly Toynbee I can remember discussions like this 20 years ago, and it is not that different.

David Pink We will all be a lot healthier in 20 years' time. The chances are that 50 per cent of the population will be diagnosed with something that is treatable by some form of intervention. If those people are going to contribute as members of society, we will need a health service that has been designed around them. Probably those people are going to want to communicate routinely with health services by e-mail, telephone and so on. They

will not want healthcare to interrupt their daily lives.

While many of the changes we are making now acknowledge the need to move in that direction, far too much of what we are doing is about how we optimise hospital efficiency. That is not the issue. The issue is how we think about the model of healthcare, and medical practice within that healthcare, that will meet those needs. We can be pretty sure that it is not the current model. We need to build a model that enables people to access the support they need from a variety of people in a variety of locations. I suspect that the issue of choice might be important in 20 years' time, but it won't be a question of whether we have choice or not. Rather, it will be a matter of the degree of choice and flexibility that is available.

Geoffrey Robinson I do not think that is the case. While I am sure that choice is important, you seem almost to be expecting it to put right what is wrong with the health service, and that is the wrong way round. If we agree that in 20 years' time we want to be in a substantially improved position to the one we are in now, then that can result from only two things. One is continued heavy levels of investment sustained for a sufficient length of time to make up for underinvestment over the past 30 years. And the second is efficiency; you have to use it better. Choice will come as a consequence of those things. At the moment, people do not ask me about choice. They ask me about improving the hospitals and all the other associated problems.

With a single monopoly provider, as it is structured at the moment, it is always going to be difficult to make the changes needed to deliver a national health service free at the point of use. I do not have any particular prescription for organisational change, nor would I want to see another one embarked on. We all agree that it has been through far too many already. However, as an overriding principle, decentralisation is a good thing. That would allow, in due course, other developments, such as increasing co-operation with the private sector. I do not see why, James, we should not put out routine operations such as hips, cataracts, knees, shoulders or whatever to specialised centres. It seems to me that the NHS should be concentrating on the really complicated care cases.

Chris Grayling You are missing one important point, which in fact we are all missing in this discussion. Quite apart from the processes of technological change, there are two great

challenges, one of which we have touched upon, which is the ageing population. The longer people live, the more likely they are going to need the health service. That is a key factor behind the pressures on the health service today. We are also seeing medicine keep people with long-term conditions alive longer, so the long-term provision of healthcare to individuals will increasingly become an issue. The other challenge is the trend that exists in part of our society towards unhealthy lifestyles, the problem posed by obesity and the rapid rise in adult-onset diabetes. The potential burden on the NHS will be gargantuan if we cannot reverse that trend. The diabetes issue in particular will be a huge burden for the NHS and will risk derailing any future healthcare strategy if we are not very careful. Do we ask people to take responsibility for their own actions?

Steve Poulton I think the very prominent position of the NHS in the nation's psyche is very important. I certainly regard healthcare as my birthright. The NHS is something I am very proud of. The flip side is that it can lead to an abrogation of personal responsibility. There is almost an attitude of "Well, I can continue to eat unhealthily and to smoke because at the end of the day the NHS will put me right. It will not cost me anything more if I use the service or if I do not."

What will need to be addressed in the relatively near future is that if we are going to continue to fund healthcare publicly, it will need some form of priority setting or rationing. Will the public be willing to fund treatment ►





► for people whose conditions result from their life-style choices?

Geoffrey Robinson No government is going to tell smokers that their cancers will not be treated. All you can do is have better public education programmes. Prevention is much better in every sense.

James Johnson It is also a very slippery slope. What I might regard as antisocial behaviour may not be what others regard as antisocial behaviour, so where do you stop?

Chai Patel Something we have touched on only briefly is that the demographic change means that fewer young people will have to support a lot more older people. There will be twice as many pensioners to working people as there are now. To pay for this, either we will have to tax double or everybody will have to work until they are much older.

Let me come back to choice. All the work that I have done looking at improvements in quality has shown that,

aside from regulation, the single greatest impact on quality in service industries comes from choice. Not because choice in itself is good, but because it creates competition and innovation. "Competition" is a word that we do not like to use in the context of the public good, but it does produce innovation and problem solving in a way that large, centrally planned systems cannot do.

The last key point I will raise is that 80 per cent of the health budget still gets spent on 10 per cent of the population in our society, which is a staggering statistic. And the majority is spent in the last five years of people's lives. Our health service is actually a breakdown service. It does not design and innovate human physiology in the way that other systems would. With motor cars, we do not mend a lot of things now. We replace them because it is easier. We have a wide capacity to research in that way, but our current funds are all used up in breakdown services.

Steve Poulton We are facing a wave of chronic diseases that will burden the health service. As the NHS was set up, it is extremely efficient and very good at fixing you when you come through the door broken. What it is not good at is reaching out to a population that is inherently well and making sure it does not get ill in the first place.

John Hutton I think the NHS is going to become more orientated towards primary care, with a greater concentration of investment in that area. Chai is quite right when he says that we spend a vast amount of resources on secondary care. Not that secondary care somehow becomes less important, because it does not. The practice of medicine and the practice of surgery have changed probably beyond all recognition and will continue to do so. It is the issue of long-term conditions that is the biggest single health and social challenge that the NHS will have to face. I think we have to move away from a model that is largely reactive and based on secondary care. You get access to the care when you are seriously ill, but you are allowed to get to that position because we do not have an effective monitoring and intervention scheme at an earlier stage.

David Pink Perhaps that is why we need the contestability and plurality or market of different approaches. We know a lot about how to help people with diabetes in a clinical setting, but not enough about how to design diabetes services that achieve optimal results for patients. It seems to me most unlikely that there is a single answer to the question, because people with diabetes are as varied a group of people as any. We need innovation. The NHS, as

currently structured, is not good at that. Our greatest failure in supporting people with long-term conditions, be it diabetes, arthritis, asthma or whatever, is not consistently and reliably delivering that support in a way that gets the patient on board.

I recently went to a conference about shared decision-making where it became clear that the number of people taking prescribed medicines was depressingly low. So we need to look at innovation in how we work with patients on the management of their conditions, because the search for an optimal, in-clinic route to tackle this approaching tidal wave is doomed, in my opinion.

Frances O'Grady But would you describe that as “choice”? My parallel experience is that I was one of the last women to have a baby in the Mothers' Hospital in Hackney before it was closed, but I was one of the first generation of pregnant women to come up with a birthing plan with my midwives. I did not want the choice of trekking across to north-west London because that was the hospital in a brochure. I wanted to go local. And I wanted to have conversations with expert health workers about how I wanted my case to be managed.

Polly Toynbee There is an idea that the private sector has this magic dust that makes everything beneficial and wonderful for everybody. If you ask people, “Does the private sector give you more choice than the state?”, they will say “Yes”. But that's not always the case. If you want something delivered to your house, you often have to wait in all day. In actual fact, the NHS now functions much better. I think we have to be careful about fetishising the idea that a market-type choice necessarily drives towards excellence. It may sometimes, but quite often it does not.

Geoffrey Robinson Choice will promote efficiency. If you look at phones, when we had the GPO as a monopoly

supplier, things were bad. It is great that competition was introduced and we have a much better, healthier, productive and computer-oriented telephone system now. I can see that type of improvement over a whole range of goods.

Vincent Cable All of the discussion so far has been about health in the physical sense; “mental” health has not been mentioned. It always tends to get forgotten in the NHS. I feel strongly about it because I had a mother and brother who succumbed to mental health problems, and incidents seem to be on the rise. Such problems are very badly understood, both their causes and cures, as is a whole range of other conditions that are on the interface between mental and physical illness, such as ME, autism and so on. Looking 15 to 20 years ahead, there may well be a growing demand for services that deal with these kinds of conditions.

Also, as genetic science advances, there are going to be growing numbers of people who will know at a very early stage in their lives that they are programmed to attract incurable conditions – for example, young women who will know that there is a very high probability that they will die of breast cancer by 50. This has enormous practical implications for insurance, as well as for people's mental conditions and ability to manage their lives. That growth of knowledge, which is driven by medical research, is something we haven't touched on. ▶





the knowledge economy now, with access to the internet, is that the person you trust, be it your nurse or GP, says, “I do not have all the ologist’s knowledge, but I have it here on the screen and we can discuss it or I can send you to the person.” The new technology offers solutions, and it is interesting how openly GPs sit with patients with the web information in front of them.

Spencer Neal The problem with preventive medicine is that we will have a society of consumers who can choose not to take the preventive treatment that will stop them from becoming patients.

Frances O’Grady In my experience, people want to be treated as human beings, not as consumers. If you promulgate the idea that they are shopping, we are going to get

what we deserve.

► **Chris Grayling** What you have just described also opens up an entirely separate set of issues. Choice is not just about operations and where you have operations. You might have a child with learning disabilities. You want that child, when it becomes an adult, to live in a village environment, but the professionals want it to live in the community. As people become more aware, informed and empowered, taking decisions and making demands in areas such as mental health will become extremely important.

James Johnson It will be quite hard to plan if, ultimately, the patient is going to decide. Choice is great, but what if the patient wants to go and see the “ologist”? That is what they do in America – though admittedly, in America, they do not have the infrastructure of general practice that we have here.

David Pink It is very important that we grapple with that question. Patient organisations have campaigned for years to get increased access to specialist care. Yet the logical extension of that for the umbrella organisation that works with them all, the Long-term Medical Conditions Alliance, is clearly untenable. They cannot all have an ologist as their primary carer.

Chai Patel When somebody has a chronic illness, at some point they want to know that they have got the best advice and are not being fobbed off. What happens with

John Hutton I do not think that is incompatible with the notion of expanding choice for patients. In a few years’ time, I think we will find it extraordinary that there was such a huge debate in this country about whether we should not have more choice. I say that because other social healthcare systems, such as that of Sweden, have had this debate. The concept of patient choice is a sound one. It is absolutely appropriate for public service organisations to work towards securing that objective. The best way to find out whether patients want choice is to ask them. When we have offered them a choice, be it in heart treatments or cataracts, they have taken it.

Polly Toynbee Let me take you up on one thing. I have just been talking to a health service manager who said that everybody wants to have their local A&E. However, A&E can’t just sit there on its own. You are setting in motion a system with extra capacity, but a lot of these local hospitals may become unsustainable. The sort of strategic planning that makes a district hospital with an A&E viable may be about to be exploded. You may well have put your finger on one of the things that explain why choice is not the only ingredient in the system.

John Hutton It is perfectly possible to run a system offering greater patient choice and, at the same time, to preserve access to A&E. In every other country

where they have done it, that hasn't been a problem.

David Green When we talk about choice in other walks of life, we are talking about price-conscious choice for the most part. With health, we are talking about a price-free choice. It doesn't really make any sense. It is a contradiction to have a public sector monopoly that is funded from taxes and provided entirely by the government, albeit with more or less decentralisation and consumers having choices.

There is something wrong with our funding mechanism. We went through a long period when we spent a lot less than other countries, and for years all the academics said,

Everyone should have access to good healthcare, but there are other ways of achieving that

“Yes, but it is more efficient.” And now, suddenly, we realise that there's been a cumulative underinvestment of £267bn over the years, and so there is a great surge in effort now. But we still have the systemic problem that we do not have a way of seeing how much money we are spending each year on healthcare as distinct from foreign holidays, cars, food or whatever. That is what is present in systems that have some element of insurance. It is not private insurance. It is called social insurance. It ensures that people who do not have enough money through their own wages or salaries have the same purchasing power as everybody else. So a country such as Switzerland, which spends the second-highest amount of GDP on healthcare in the world after America, has a social insurance system, and about a third of the people in that country get a subsidy, which is fine.

My point is that if you go back to first principles, everyone should have a high

standard of healthcare, regardless of their ability to pay for it, but there are other ways of doing it. If we look 15 years ahead, we might decide that some other countries have found a better way of doing it than us.

Spencer Neal Does that not imply that health will become an aspiration in the way that exotic holidays and new cars are? And does that not mean that in 15 to 20 years' time there will be just as marked, if not greater, a disparity between the wealthy and the less wealthy as there is now?

David Green In America, where there is a “two-tier system”, private for the rich and state for the poor, the state cannot fall too far behind. Switzerland is the same; the government has a committee that draws up a basic package.

The political dynamic is that you cannot leave very much out of the package. In America, for example, people are wanting their hips and knees done in their eighties so that they can go on playing golf.

Frances O'Grady But some of the worst health inequalities in the world exist in America.

David Green But I am saying that there is no inequality. You find people at all levels of society who can get their hips and knees done. ▶





David Pink Do we want further change driven by the need to have a more efficient waiting list system? Do we think that should be the driver for the next phase of change in our health services? I'd argue that it would be a dreadful mistake to do that. That would not address the most important issue on the health agenda. Beyond a certain point, driving down the waiting lists further would actually be dysfunctional. It would be to move our resources in ways that we should not be moving them.

Vincent Cable Once you strip away one tier of the waiting list problem, you have another tier underneath. There are very prolonged difficulties of people waiting

for angiograms and MRI scans. If that system worked quicker, your waiting lists would resurface in a much bigger and more difficult form.

Polly Toynbee Can I throw in a Canadian approach, which I rather like? Canada was having problems with some very tight targets until it said: "Let's just have one target: that all patients must be 10 per cent more satisfied with whatever it is they are getting." This suddenly opened the door. There might be lots of things that we

Canada decided it would have just one target: that all patients must be 10 per cent more satisfied

would not have as targets in this country – for example, people being nice to patients, so that it's fine if they are still dropping dead, as long as they are happy. As it is, we keep delivering targets and everybody is whingeing. Perhaps the target should be to make people feel that delivery is happening.

David Pink The things that Vincent mentioned matter just as much as those surgical waiting lists. There are

► **Frances O'Grady** I don't think so.

Geoffrey Robinson In the States, something like 40 million people are completely uninsured.

John Hutton If you look at the comparable international evidence, you would be hard-pushed to find another healthcare system that is run as efficiently as our tax-funded system.

Chris Grayling The big drawback in this country under the current system is that we cannot get treated when we want to. I remember asking a consultant in the main hospital in Belgium how long his waiting lists were. He looked blank. They did not exist. The reality is that we have a very large number of people waiting at all levels in our healthcare system, so we cannot say that what we have today is the most effective system.

Polly Toynbee Does that mean that when we get the waiting lists down in five years' time, if they continue falling at the current rate, there will be virtually no waiting lists?

Spencer Neal You mean that people will barely have time to go home and get their pyjamas?

Chris Grayling I do not recognise that scenario.

people waiting for a diagnosis. In medical terms, undiagnosed people are not a particularly big problem. In many cases, they are waiting for a diagnosis for which there might not be an effective treatment—for example, all those with neurological conditions. By and large, there is not much we can do for them, and giving them a diagnosis does not improve the population's health. In fact, it worsens it, because you then have to count them as having that diagnosis. I quite like the idea of the happiness index. I dread to think what we would do when we started codifying and measuring it.

James Johnson So we should flee from evidence-based medicine, start smiling at people and everything will be OK?

David Pink No. We would still want evidence-based medicine, because being made better and cured makes people happy, doesn't it?

John Hutton I do not think we should be too pessimistic, for two reasons. The first is that I am fairly sure that the product of research, technology and everything else will allow us to make more effective interventions, as we are currently doing. The survival rates of people with cancer and heart disease are proof of that. There will still be a cost to the NHS because those interventions are usually expensive, but that is something we have to deal with as a society.

I think we should be fairly confident, too. Take smoking, for example. In the past 25 years, there has been a significant change in smoking habits and I am sure that people will continue to become more health-conscious. However, the reality is that some people will continue to smoke, binge drink or eat the wrong foods. This will be a real challenge for British governments for the next 20 to 30 years. It will be the challenge of prosperity, if you like, and affluence. If you go back to the 1950s, I am sure that people said, "When we are all richer, we will be healthier." Strangely, that does not seem to be true. We are immeasurably wealthier as a country, but most of the measurements of public health do not look very encouraging.

Chai Patel Except that we live longer.

David Pink We live longer and we live healthier. If we add up all the numbers of people who have a diagnosed illness, then we will all be a lot unhealthier in 2020, because half the population will be ill. But we will in fact be healthier. Whether you measure it by quality of life, the ability to

perform daily functions, to work or whatever, there is every chance that we will continue to be healthier. The problem is that people's perceptions and expectations are advancing at a faster rate than reality. As we come up with a diagnosis and a label for every human frailty, they will expect some treatments.

John Hutton What I was referring to is that I think there are likely to be more people with chronic diseases.

Chris Grayling We have to use smart education to encourage people to choose better lifestyle choices, otherwise we are going to have a huge health problem.

Polly Toynbee So what about banning smoking, then? One might say that would be a prime thing to do to try and encourage cultural change, but people have been very reluctant to think that governments should or could affect social change. ▶





► **Chris Grayling** I don't think the government can ban smoking.

James Johnson Of course it can. Banning smoking in public places has been done all over the world.

Steve Poulton People have mentioned advances in technology. If these advances are used to help tackle chronic illnesses, then at some point in the future we will probably be able to predict and prevent, genetically, Alzheimer's, cancer or whatever. That raises all sorts of ethical questions. How far do you want to take the preventive agenda? And then there are questions about who has access to that information.

Frances O'Grady Technology is great, but in the excitement about it we sometimes forget the more basic obligations of society. For example, if we continue to make progress in eliminating child poverty, that will have a huge impact on health.

Chris Grayling There is one thing we are forgetting in all of this. I had a problem with the gearbox in my car

recently. I took it to the main dealers. The mechanic came out to have a look, pulled out a laptop, plugged it into a socket underneath the dashboard and said, "You have got a problem with that. It has happened 38 times." We are going to get to that point with healthcare. Sooner than we think, I suspect, we will be able to put our hand on a device that will tell us huge amounts about our health. We will be able to send analyses from that equipment to our doctors, who will then say "Come and see me quickly" or "There is nothing to worry about".

Chai Patel In a publicly funded system, you will create inequalities if that kit is available only to people who are going to buy it for themselves. That is something we need to think about. Any device that we get in the future is going to have to be free to everyone. That is what makes it so egalitarian and helpful.

Another point is that there has been an IT revolution in every other service in the world except health. The problem is that our data is all over the place. We have to rely on episodic pieces of research to understand things. Ours remains a paper-based system, while countries such as Malaysia and Singapore have excellent IT systems in place

because they have started from scratch. Emerging economies will go the same way and we will have to catch up. This is quite an important point for researchers, who need the data to understand things.

John Hutton IT will be absolutely central to the quality of health in 20 years' time. People often ask me why the NHS doesn't absorb evidence more quickly. Why is it that you can go five miles down the road and see fantastic services, yet if you go five miles in the other direction the services are not as good? It is about information-sharing and applying the power of the new technology. There is so much more we can do to prevent adverse incidents in delivery. That is what people in the future will be interested in.

Frances O'Grady We have spent a fair bit of time discussing technology, but what about the workforce? The people who deliver the service are the single most important factor in improving that service. What about investing in skills as well as computers?

Spencer Neal The workforce will clearly need to be much more skilled and knowledgeable. But going back to the beginning of this conversation, information is not the same as knowledge. With the information on a national level, which can only be gathered using IT, we could have spotted trends in obesity and other chronic ailments decades ago. The workforce would have been informed and understood what to do with that information. Hopefully, in 2020, that is the kind of healthcare we will have.

Polly Toynbee That is exactly the wrong way to look at it. It is not about computer systems. It is about what happens between the patient and whoever is trying to help them. I think that is desperately difficult. It is what matters most, and what politicians think about least.

Spencer Neal But isn't that social care?

Polly Toynbee It is whoever is doing the delivery; it is not an "ism" or a system.

Chai Patel People who go into social care come from a totally different world to people who come from a nursing or medical background in a clinical setting. These two cultures bang away at each other and look at the world totally differently. If we want the system to change, we have to change the education and the way in which the education works as well. Most medical education still

works in secondary settings, not in primary settings. That is changing, but it is still mostly secondary.

John Hutton Those areas have to be resolved within the professions. It is a mistake for politicians to get involved in that sort of thing. I think the biggest capacity constraint we have in making the NHS become the service we want is human resources. It is not capital – we can build hospitals – it is people. I do not think there is a magic wand. The demography of the caring workforce is changing. Eighty per cent of our staff are women, and that figure is likely to increase. And yes, it will cost taxpayers more to invest in the workforce if the NHS is going to expand in the future.

The demand for science graduates in the NHS is huge. I forget the figures, but I think half of all science graduates are needed by the NHS, and we are competing with a range of other employers all the time. We have to improve terms and conditions. It is true that people do not come into the NHS to make a fortune, but they have to be properly valued. If we do not address this issue, we will end up taking staff from developing nations, which is inappropriate. We have to tackle this problem for both ethical reasons and international solidarity. I think we are going to have to address it in simple economic terms.

Chris Grayling We also need to change the relationship between politicians and the workforce. We need the inverse pyramid model. At the moment, we have a top-

The job of a minister should be to sit at the bottom of the pyramid and push responsibility upwards

down model. But the job of a minister should be to sit at the bottom of the pyramid and to take steps to push responsibilities upwards, to make it easier for the professionals to do their jobs.

Margaret Mythen I would like to bring this debate to an end and thank you all for coming today.

Spencer Neal On behalf of the *New Statesman*, I would also like to thank you all for your time. And thank you to Pfizer, who have worked very closely with us to enable this event, the first of six, to take place.

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