

Life begins at 60: what kind of NHS after 2008?

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THE YOUNG **Y** FOUNDATION

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Because of its daily struggle to cure ill people, the NHS has become, paradoxically, a 'sickness service' rather than a health service. Yet, beyond pointing out the causes of sickness in society, everything from pollution to stress – what would a National Wellness Service look like?

nef (the new economics foundation) and the **Young Foundation** have teamed up to launch a project that will map out a health service for the UK that goes beyond just tackling illness and does what the NHS was originally intended to do: keep people well and put wellness at the heart of policy.

*This is a **draft** prospectus for the project, the final version of which will be launched at the end of 2006. Please let us know what you think...*

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Published by:

new economics foundation (**nef**), 3 Jonathan Street, London SE11 5NH.
www.neweconomics.org

Young Foundation, 18 Victoria Park Square, London E2 9PF.
www.youngfoundation.org.uk

Final publication: Nov 2006

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“No change is made in this figure as from 1945 to 1965, it being assumed that there will actually be some development of the service, and as a consequence of this development a reduction in the number of cases requiring it.”

Estimate of the cost of health services, Beveridge Report, 1942.

Lord Beveridge was not the inventor of the welfare state. But his was the vision, the rhetoric and the intellectual underpinning, and his famous report – published at the height of the Second World War – was that unusual creature: a government publication that becomes a bestseller.

It was Beveridge who coined the phrase the five giants – and it his giant, Disease, that this document concerns itself with. In many respects, the 60 years since he reported have brought great improvements in healthcare. Universal access to hospitals and doctors has come to be seen as one of the marks of a civilised society. Yet when you delve into his report *Social Insurance and Allied Services*, you discover that many of the assumptions that underpinned the NHS were radically wrong.

One was the assumption that an NHS would become more affordable over time: an assumption which was so ubiquitous that it was barely argued. Like other advocates of a national health system, he believed that it would lead to rising levels of health, and therefore lower costs as its effects came to be felt. Another was the assumption that the primary tasks of the NHS would be primarily to deal with moments of crisis – acute illnesses, births and deaths

More than six decades after his report, it is now clear – and not just from the UK – that the prediction of lower costs was quite wrong. Far from a gradual improvement in health and a reduction in costs, health services the world over see the very opposite happening.

Exactly why this should happen remains controversial, but there is consensus at least about the range of candidates for blame. Expectations rise, life expectancies rise, the research costs of drugs rise, and therefore the drugs themselves – a major political issue argument that has yet to bark in the UK. Another factor is the tendency of all very labour intensive services to become more expensive over time. But the basic problem is that one of Beveridge’s assumptions was also faulty: although the customers of the NHS did improve their health, success in tackling one set of diseases only moved attention to other kinds of disease. In other words, the diseases of the 1940s have given way to twenty-first century chronic health problems as well as ageing – American health economists say that 90 per cent of health spending goes on the last ten per cent of people’s lives.

The priorities of two generations ago were diseases like tuberculosis or polio. Today’s chronic diseases – like asthma and diabetes, depression and multiple sclerosis - do not usually kill, or at least not quickly. But they are causes of misery and a giant cause of misery to the finances of any health service. As many as 80 per cent of GP consultations now concern chronic ill-health, rather than the kind of health problems where traditional forms of intervention seem appropriate. A similar proportion of the NHS budget now goes on tackling chronic disease, and the incidence of chronic disease in the over-65s is expected to more than double by 2030.

This is a particular problem with the range of issues around immunity: the massive rise in allergy problems, of asthma, eczema and hay fever, as well as more intensive immunity problems like ME and Aids, and growing controversy about childhood immunisation.

Mental illness is particularly problematic, when ten per cent of the population suffers from serious depression at any one time, when nearly a third of all GP consultations relate to mental health problems, and when more than 900,000 are claiming sickness and disability benefits for mental health problems.

Taken together, this means that a health system shaped by nineteenth and twentieth century issues about contagion and acute disease, now has to cope with a very different kind of epidemic, but without having yet developed the means of coping. It means that much of the contemporary health policy debate – with its focus on building ever bigger hospitals, more choices of treatment and expensive technology – often misses the point.

Not surprisingly, the standard NHS response to chronic disease, which was shaped by the perspectives of a generation ago, is often out of keeping with what patients really want. The standard medical response is often to maintain patients on drug treatment for the rest of their lives, when research shows that changes in diet or social involvement can make a difference and save the NHS money - if not at the same time, then some decades later.

Again, the exact balance of causes behind this rise in chronic disease remains debatable, but rising stress – from burgeoning house prices, work stress and debt – is likely to be among them. So too is loneliness and isolation. So is atmospheric and chemical pollution, and the broad spectrum of causes known as 'lifestyle' – diet, alcohol and drug abuse.

These are all broad issues, the levers for which go far beyond those at the disposal of the NHS. They give rise to questions at the very heart of modern society, and why it should give rise to such alienation. Yet, if the NHS is not to be steadily overwhelmed by the various effects of this alienation, then some levers must be found – to intervene at some point on the chain of causality. The question at the heart of this document is this: can we imagine a health service that might be capable of tackling the rising weight of chronic, lifestyle or isolation disease?

There are few levers that NHS staff, with their commitment and imagination, can now use. Yet the implications of ignoring the problem are undeniable: an increasingly polarised debate between the defenders of the status quo and advocates of greater marketisation and consumerism. This prospectus argues that the biggest challenges of the next two decades will make both of these positions look increasingly inadequate and anachronistic. That is why we want to map out how the NHS might evolve to better meet the real needs of the people who depend on it.

Mental illness and depression

- Mental Illness accounts for a third of illness in Britain. Some 40% of all disability (physical and mental) is due to mental illness.
- One in six of the population suffer from depression or chronic anxiety disorder.
- About 2% of NHS expenditure goes on dealing with depression and anxiety.
- 12.8 million working days were lost to stress, depression and anxiety in 2004/5.

Basic problems

"If man thinks about his physical or moral state he usually discovers that he is ill."
Johann Wolfgang von Goethe

In common with most other advanced Western economies, our healthcare system is primarily focussed on the task of providing cures for ill-health. The task of developing and providing more preventative interventions which focus more on the causes of ill-health and sickness, is clearly an ambition - even an objective with some policies attached - but it is hard to imagine how much progress can be made towards that with the system as it stands.

Important as curing people is, there is a sense of growing unease that so little is being achieved to address the fundamental causes of ill-health. The two Wanless reports, commissioned by the Treasury, underlined this sense: Derek Wanless concluded that the NHS could survive and thrive only if people took more responsibility for their own health, and warned that it would cost £60 billion more to run by 2020 – not much less than its budget now – if these problems were not solved. As it is, the system seems to teeter on the edge of collapse in the face of overwhelming demand. The NHS is one of the few remaining open access points in society where people know they will find a human – not a virtual online service – who will listen to them and who will be nominally on their side. The development of expensive health technology threatens, on present form, to overwhelm national finances if demand is to be met.

In response to this, two health white papers (in 2004 and 2006) have outlined Department of Health plans to shift the emphasis of the NHS towards prevention. It will do so by increasing 'personalisation' by practice-based commissioning, more payment by results, expansion of the Expert Patient scheme and closer links with social care agencies (*Our Health, Our Care, Our Say*). And by maximising the 1.5m contacts the NHS has with patients every day and "building a closer alliance between the NHS and society" (*Choosing Health*).

But the rhetoric in the earlier green papers is not generally reflected in actual plans. Understanding of the problem is only reflected in a very limited way in the budgets or targets, and even those who are sympathetic to major change tend to find themselves shying away from major re-allocations in the government spending reviews. There is more voluntary activity around the NHS, but evidence from recent research by the new economics foundation (nef) into 'co-production' between professionals and patients (see below) shows that, in practice, NHS structures actually corrode the voluntary organisations that are trying to achieve this. The official emphasis tends to concentrate on early detection, rather than prevention, because that is more achievable by the institutions that actually exist now.

To be more specific, progress towards the national wellness service is being frustrated by the following problems:

- Too much power in the hands of professionals who have been slow to understand the changing demands of patients; a consumerist approach to care which though appropriate to certain kinds of operation and choice encourages an assumption that most problems can simply be fixed by drugs without any other effort on their part.

- Fast food diets, increasing ignorance about good nutrition, stressful lifestyles and workstyles, and drug and alcohol abuse. Current structures are unable to go much further than awareness-raising to scare people into lifestyle change. Bizarrely, this attitude to lifestyle is reflected in the unhealthy nature of much of the food that is now served in hospitals.
- Rapidly growing levels of chronic disease – related to the current crisis over the numbers on Incapacity Benefit – which the current model of healthcare is not designed to address.
- The atomisation of society and the consequent unravelling of family and neighbourhood structures that were better able to support people in their recovery. We know that the health risks of lacking social networks are as high as smoking, yet there are few levers that the NHS can currently pull – as they are currently organised – that can regenerate this aspect of people's lives.
- The weakness of the causal evidence that specific changes in public health will have specific outcomes – beyond the obvious effects of giving up smoking). For example, the wellness effects of lower stress while obvious to anyone who has managed to tackle their own stress are hard to prove to the satisfaction of health economists.

Add to these the impending end of the current phase of investment in 2008, by which time it seems clear that economic conditions will probably require large-scale expenditure cuts. Some critics suggest that not only will our healthcare system be dependent on large levels of funding which are no longer forthcoming, but it will increasingly lack the experience, structures, capacity and inclination to tackle the root causes of rising ill-health.

By then, there will have been further entrenchment of the current incentive structure within the NHS, so that providers are increasingly rewarded for patient throughput and units of care delivered – but not for moving people out of day-to-day patient care or helping them avoid needing the NHS in the first place. The target culture also seems likely to make it harder for frontline staff to use their skills and experiences independently and experimentally on the kind of innovation that can reduce ill-health.

But even beyond the difficulties of administration, there is a basic economic problem. Shifting to a 'wellness' system will be expensive, and doubly so because the demand-led illness system has to be continued – that is absolutely vital to the health of the nation – while the extended wellness service is entrenched. No plans for a new kind of NHS are worth considering without also considering how the switch might be paid for.

Chronic illness

- 41% of the economically inactive suffered from ill health 2001.
- The proportion of workforce inactive due to illness increased from 14% in 1993 to 20% in 2001.
- 17.5 million Britons suffer from chronic health conditions.
- Direct costs attributed to long term sickness are estimated at £11.6bn, including provisions for sick pay, staff replacement and loss of productivity.
- Long term illness made up only 5% of all sickness, but responsible for a third of the total number of working days lost.

Basic solutions

“They have no doctors, but bring their invalids out into the street, where anyone who comes along offers the sufferer advice on his complaint, either from personal experience, or observation of a similar complaint in others... Nobody is allowed to pass a sick person in silence, but everyone must ask him what is the matter.”

Herodotus, *The Histories*, on the Babylonian healthcare system

Despite these intractable blocks on progress, there are opportunities:

- The existence of pioneering practice around the margins of the NHS and in the voluntary sector which potentially offer radically different solutions, but which are currently isolated and making little impact on the mainstream.
- There is recognition at the highest levels that something urgently needs to be done to address the problem of chronic ill-health, and policy already being put into effect.
- There is already more collaborative working at primary care level between different sectors, in local area agreements, and the growing control that primary care has over purchasing. Although they are administratively different, most of the public does not draw clear distinctions, for example, between health and social care.
- Growing public demand for ‘complementary’ health treatments, currently used by up to half the population, the vast majority of them outside the NHS. This may also have less welcome effects – American research suggests that 80 per cent of cancer patients may use complementary solutions, even though they may lessen the impact of their conventional treatment – but it is a sign of people taking more responsibility for their own recovery.
- Expert Patients and other experiments inside the NHS which allow patients to be equal partners with professionals in the delivery of healthcare.
- An innovative and committed staff, with direct experience of frontline services, and a public service ethos that motivates their work.

We are also entering a period when, because of the intense pressures on the NHS described above, we are likely to see a series of radical innovations in the way healthcare is organised. These are as likely to be about how care is organised as they are about new drug treatments, and they come broadly under the following headings:

Co-production with patients

It is clear that an increasing proportion of chronic diseases are largely the result of individual, social and environmental factors, which would be preventable in principle if people’s behaviour could be changed. In fact, long-term treatments for chronic ill-health depend at least as much on what patients do as on what medical staff do – and probably very much more.

The problem is that existing healthcare systems tend to focus on diseases rather than on patients, and are normally downright bad at mobilising

the energy, resources and will of the patients themselves – all of which are absolutely vital for dealing with the problem. Ideal patients, under the current system, are passive and grateful, which are also precisely the wrong attributes for tackling chronic disease. Often patients come to know more about their individual patterns of illness, how to handle pain, motivate themselves and use networks of support than the doctors treating them, yet this knowledge is often discounted by the professionals.

Co-production describes a more effective model for healing, where the responsibilities and knowledge are shared between health professionals and the patient, and sometimes (see below) with the patient's family and neighbours.

The Expert Patient programme is a good example that illustrates how this contribution can be realised, and how things may be gradually changing. The programme recruits volunteers with direct experience of chronic ill-health to deliver self-management training through local PCTs and has had remarkable success. The programme implies that, where patients and health professionals act together to co-produce a positive outcome, there are long-term reciprocal benefits for all: volunteers are recognised as assets as a result of their experience, participants are more able to live successfully with their conditions, and professionals are less likely to have to deal with problems that are essentially self-managing.

This is not a new insight. Over 400 studies of self-management have shown that programmes providing counselling, education, feedback and other support to patients with chronic conditions can dramatically improve their conditions. The Michigan Diabetes control programme was able to reduce hospitalisation by 45 per cent for participants, and cut deaths by two per cent.

There are innovative professionals in the NHS who are developing new approaches along these lines, though they also have colleagues who do not see it as their job to encourage this form of co-management, partly because they lack the training and partly because they lack the support structures. Both of those are likely to be crucial to a new model NHS in the future

Co-production with patients' families and neighbours

Healthcare which relies too much on professional or pharmaceutical expertise tends to overlook the vital contribution, not just of patients, but of their families and neighbours, and how these can keep and make each other well.

The difficulty is that these mutually supportive social networks were much more widespread – though largely informal – in the days when Beveridge was writing, and have now largely disappeared. There is evidence, for example in Michael Young's *Family and Kinship in East London* (1957), that this was a deliberate destruction on the part of the new NHS professionals, who feared the 'ignorant' influence of families in impoverished communities. Their disappearance has contributed to the culture of ill-health in some of these communities today.

Loneliness and isolation

- Young Foundation MORI poll found that young people are most likely to feel lonely. 25% of 15-24 year old said they feel lonely at weekends.
- 18% of 55+ admitted going a full day without speaking to anyone. 2% of respondents have telephoned the Samaritans or other emergency helpline in the last year.

Yet there is a growing understanding in some parts of the NHS, especially in mental health, of just how vital social networks are to recovery. “How do you put Humpty Dumpty together again?” asks Professor Tom Craig at the Institute of Psychiatry, explaining that he knows how to get a patient to talk about a mental problem and how to prescribe the right drugs, but is powerless to provide what he knows is the best medicine: friends, social networks and work.

The term ‘co-production’ originated as a term to describe the critical role that service ‘consumers’ have for the success of professionals. It was originally coined in 1972 in Chicago, when research there found that neighbourhood crime rates went up when police stations became centralised and police stopped walking the beat and lost their vital connections with local community members, but has also been deepened and put into a broader context by the work of the civil rights lawyer Edgar Cahn.

The new economics foundation (**nef**) has been studying the development of the kind of co-production in health: co-operative local support patients need to tackle ill-health, sometimes in partnership with local public service providers, sometimes independently of them. Often this means broadening and deepening the meaning of health service – volunteers from the Rushey Green Time Bank, for example, in a doctor’s surgery, can provide a friendly face to isolated patients better than professionals ever can. And, the evidence is that this intervention is absolutely vital to recovery.

This may be the basic insight behind the development of a wellness service: patients are assets that must not be wasted. A wellness service will recognise these as assets, value and reward them, and develop institutions capable of putting them to use. Yet those institutions capable of doing so are now either in the voluntary sector (Green Gyms) or inside the NHS (patient support groups). Only a very few manage to bring these systematically into the mainstream, in the way that the South London & Maudsley’s Cares of Life Project collaborates with churches in Peckham to promote good mental health and recovery across the local Afro-Caribbean community.

Building relationships with professionals

Charles Leadbetter’s concept of ‘personalisation’ suggests that the future of health services lies in tailoring them to individual needs and preferences, and it is true that co-production and co-management mean a much more customised approach to healthcare. But the future NHS is likely to require something beyond tailoring treatments to individual genetic make-up – which may turn out to be costly and ineffective – or matching services and support to individuals and their culture and social networks, to give an ever more complex and ambiguous series of personal choices.

This is bound to be the direction of change, simply because it is more effective. But co-production and co-management also imply that patients need a relationship with healthcare professionals, and that relationship – rather than the conventional public health levers of advertising and frightening statistics – has the capacity to drive lifestyle change.

Much of the NHS currently seems to be moving in the opposite direction. Patients in the USA are interrupted by doctors within 22 seconds, and even in the UK the average doctor spends only a dozen minutes or so with each patient. Worse, hospital patients now rarely see the same doctor twice, and it can be difficult getting appointments which maintain a relationship with one GP, especially in large practices, though patients do value that continuity (confirmed by research in Edinburgh, 2002). Without that central driving relationship, ‘informed consent’ can be reduced to screeds of impenetrable statistics, and health checks simply to tickboxes.

Yet there are developments in the opposite direction, not necessarily with doctors, to provide people to work alongside patients. Some successful innovations, like Newham University Hospital's chronic illness project, provide 'community navigators' to work with patients towards the right health and social care, and in many ways all health organisations are considering how patients can navigate between choices. Cancer charities like Macmillan are also experimenting with guides who can do the same for new cancer sufferers.

Many of these developments are purely about finding information, but there is nonetheless a relationship at the heart of it, and this can be vital – especially when recovery might require social support that goes some way outside conventional pharmaceuticals. It is hard to see how an NHS that puts choice at the heart of its future can avoid finding some way to re-inject personal relationships – though not necessarily with doctors – into the frontline services.

New kinds of organisation

New social movements, especially those providing people with support from other people suffering from similar conditions, have emerged with ever greater energy over the past decades. A similar reaction against the formal health system is discernable in the rise of the disability rights movement. As many as 100,000 people join Weightwatchers programmes every year: they may return to their previous weight, but it is at least an example of health effort outside the NHS. There are organisations like NCT, Mind, the Alzheimer's Society and Macmillan Cancer Care, which provide sophisticated support services outside the NHS, and other lobby groups which pressurise governments for research or support for their genetic disorders or new drugs, putting even greater pressure on NHS finances.

When a third of the population of the UK now consult complementary health services – though this includes people who just take vitamins – that may be an implied criticism of conventional healthcare, but it is also a growing democratisation of health and a sign of an increasing confidence among patients. There are dangers here too: what are patients to believe when they no longer trust the authority of the government medical spokespeople, just as they have learned to doubt reassurances about MMR?

Obesity and damaging consumption

- Obesity among adults has risen by 300% in the last 20 years in the UK, with 1 in 5 adults being classified clinically obese. In England, 22% boys and 28% girls aged between 2-15 years are either overweight or obese.
- Nearly two thirds of men and over half of women are overweight or obese, at an approximate cost of £2 billion a year to the economy.
- Alcohol-related deaths in England and Wales rose 18.4% between 2000 and 2004 – deaths from cirrhosis of the liver have risen 500% since 1970.
- In 2002, 10% of secondary school children aged 11-15 smoked at least one cigarette per week. One cigarette is equivalent to 11 minutes of life expectancy.

Since the Beveridge Report, the whole definition of health has extended from major threats to life and livelihood into something that is much more about wellness promotion, quality of life and the kind of strategies and make-over propaganda you find in magazines and national newspapers every day. Yet the experience of voluntary organisations locally, working alongside professionals in the community – though they are of proven worth to those who are involved – is that public sector management systems tend to undermine them. They require the kinds of accountability that broad-based semi-informal organisations of this kind are simply unable to provide. Conventionally narrow target regimes do not recognise their worth, and they fail to provide the security of funding that any formal department in the NHS takes more for granted.

A national wellness service will have to solve this conundrum, find ways of blurring the distinctions between patient and professional – between professional and voluntary – in its management systems and attitudes, and to make the benefits of these new forms of organisation more available systematically. And even, perhaps, providing extra benefits for those who make the effort.

Environmental levers

Medicine since Beveridge has tended to emphasise individual patients, and the enormous breakthroughs in public health led by nineteenth century pioneers like Edwin Chadwick have been sidelined. Even modern innovations like the Pioneer Health Centre in Peckham – which deliberately set out in the 1930s to positively increase health – did not survive long into the NHS. The healthy living centres that were designed in the 1990s to do something similar are also being allowed to wither on the vine.

The new century emphasises how health is impacted by environmental factors like toxins, pollutants, junk food or smoking – as well as by the social environment by isolation. The tension between this obvious insight, and the fact that they are the direct and often deliberate results of mainstream consumer society, lie behind many of the knottiest political issues of the age.

The impact of Jamie Oliver's campaign on school meals have made those connections even clearer – between the poor diet given to children at home and in school and poor behaviour, poor attention and poor health. His television programmes tracked the massive drop in asthma among children eating healthy school lunches. We already know that other lifestyle changes can have a massive effect on health: 80 per cent of coronary heart disease cases and 90 per cent of type II diabetes could be avoided by simple changes in lifestyle. It is obvious that a national wellness service would need some levers to influence people to exercise and eat better.

The difficulty is that, beyond providing people with more information on packaging, for example – and scaring them through advertising and the media – there seem few levers yet developed that are likely to have any impact, and people are increasingly immune to both of those. Once again, relationships with other sufferers and with professional staff do seem to be a potentially effective way forward – and better information once people are motivated.

There will need to be a massive expansion in fuel tax or road tax for most polluting vehicles. There needs to be other forms of reward for those making an effort to maintain or improve their health, either in the tax system or in lower insurance costs. Or in smartcards, like the Nu Spaar-pas experiment in Rotterdam, that reward those who improve the environment or health by their behaviour or purchasing.

But there will also need to be levers on the behaviour of institutions as well: charges on those institutions – public or private – that cause illness, whether unhealthy workplaces or unhealthy eating. Exactly what those charges should be will wait on the development of green taxation that allows those organisations that damage people's health to pay into the healthcare system, whether they make their employees ill, pollute the atmosphere or promote binge drinking. There needs to be policies to encourage the new companies that are emerging that make their profits from the improvement of health and will, if the economic signals are right – undermine those that make their profits out of reducing people's health.

New kinds of knowledge

The information flow in the NHS is improving, despite the problems of the NHS computer system. The precise risk factors and risk indices of every treatment are available, both for drugs and ever smaller segments of the population. But it is increasingly clear that different kinds of knowledge are just as important to health in the future – about social, psychosocial and environmental aspects of health – and different kinds of information management to guide patients through a much more complex series of possibilities.

Even where there is knowledge about social causes, they exist in a different world to the drug-based professional research that uses most of the research money in the UK. It is not clear that, for the enormous sums spent on developing new drugs, the broader benefits to patients justify the costs – if it means that the social innovations we need go un-funded. It is clear that NHS R&D is going to have to emphasise social innovation, and cross-disciplinary insights, as well as promoting wellbeing, considerably more in the future.

This also implies different views about the way knowledge should be organised in collaborative and open systems, because these are fields where proprietary knowledge protected by legal controls of the kind favoured by industry are less likely to be efficient. It may mean that we need other kinds of organisations to be geared up to carry out the research that is needed.

The problem with conversational forms of research is that social medicine is an area where cause and effect are very difficult to pin down, and so old-fashioned decision-making can be atrophied by the failure to come up with clear answers – or clear prescriptions either. There is a mismatch between the knowledge and the lack of understanding about what institutions and interventions are needed. In particular, the whole business of measuring wellness has been traditionally fraught with difficulty. But there are ways of benchmarking progress that are emerging, and new ways of building an agenda which uses this knowledge effectively.

Broader and deeper NHS

It is hard to see how the new NHS can achieve its objectives without interpreting health considerably wider than it currently does. There are good administrative reasons now for keeping the definition narrow – excluding as it does a great deal of low grade psychological malaise and loneliness – for fear that services would otherwise be overwhelmed by demand. But the ability to find any kind of lever on chronic disease requires that the new NHS organises itself to be very much more systematic about wellbeing.

That means more multidisciplinary teams that straddle psychological, medical as well as social, elements of recovery, and new forms of organisation and mutual support. It means new forms of measurement that

can successfully track differences in wellbeing, new partnerships with other government agencies and professional disciplines.

It also means embracing more of what is currently described as complementary health. The ignorance, for example, of many specialists about mainstream insights in complementary health – the impact of diet, nutrition and relaxation, for example – increases the expense and the trauma for those looking for tailored alternatives, and increases also the dependence of those suffering from chronic conditions, which might well improve if they shopped around. There is also a gap in knowledge about the interaction between complementary and conventional treatments.

One of the insights that complementary practitioners possess, and which traditional medicine has lost, is the vital involvement that is required of patients to recover. That is central to respectable complementary disciplines from homeopathy and acupuncture to shiatsu and osteopathy.

Behind all this is the question of what basic shifts will enable these changes to take place. These include:

Financial reform: There is a wider challenge here for finance managers and accountants, and a requirement for new kinds of accountancy that can identify more precisely the effect of impacts that one budget might have somewhere entirely different in government spending. There is little motivation on NHS administrators to invest in wellness if the financial benefits of doing so accrue entirely in somebody else's budget.

New resources: There are resources for building the new national wellness service that exist, theoretically at least, outside the NHS. One place is in the skills, knowledge and time of patients, their families and their neighbours. These are underused assets – sometimes completely wasted – that could be engaged, not just in their own recovery, but in developing broader services of befriending, checking on hospital discharges or mutual support, and rewarded in some way for their efforts, rather as they are in a GP's surgery in the Rushey Green Time Bank in Catford.

New financial instruments: Another place where resources might be accessed is in the savings in NHS spending in two decades time, if these investments are made now – just as new companies fund their start-ups by borrowing from the profits they will make in the future. The cost of not building the national wellness service has been set out in stark terms by Derek Wanless in his two reports. That money is there to be saved, and drawn forward to make the investment capable of making the savings, if we can develop financial instruments – which might be related to bonds, but might be related to the new Energy Service Companies that are financing energy-saving investment – that can manage that investment over a generation.

Co-design: The concept of 'co-designed' Open Health, developed by the RED team at the Design Council, which have shown how it was possible to redesign services alongside patients with diabetes to make them more effective, using their skills as designers. The application of Toyota's Lean programme to re-designing hospital systems in Bolton and the Wirral is an example of the benefits of doing this with NHS staff (the Lean programme was developed originally as a way of increasing the speech, quality and efficiency of Toyota factories). But all these new initiatives and new thinking needs to be pulled together, and brought into government thinking so that it happens in a way that has some chance of coherence and widespread success.

Signposting: The development of a new kind of professional – who might actually be a volunteer – who guides patients through the multiplicity of social and medical options open to them, looks set to be one of the most far-

reaching developments in recent years. Signposting can be done virtually, but it usually has to be a human interaction – more of a mentoring relationship – which has been developed in the cancer care charities and other similar voluntary organisations, and which enables genuinely self-managed care. It may be a model for a much more diverse NHS in the future.

Democratisation: There may be other ways in which responsibility can be devolved to patients. Should, for example, groups of patients be able to band together as a purchasing unit – with safeguards to avoid this becoming a backdoor privatisation – as the successful experiments in Solihull are showing? But there are also questions made about how far health spending decisions can be devolved and what sort of innovations would make it possible to devolve them further. The basic guarantees of health underpinned by Nice, for example, could be re-imagined – not as a tool of centralisation – but as an underpinning for more local democratic control.

What next?

“He that will not apply new remedies must expect new evils; for time is the greatest innovator”

Francis Bacon, *On Innovation*, 1597

We might know what direction to seek the new NHS, but there are specific questions that still need answering in order to be more precise about how it is likely to emerge in practice. These questions lie at the heart of the proposed research project now being launched by the Young Foundation and the new economics foundation (nef). They are:

- Are there better healthcare delivery structures that can help patients get to grips with chronic health problems?
- How can commissioning systems incorporate the broader social objectives that underpin a Wellness Service?
- Is it possible to develop a system of accountability that provides equal, sustainable and effective relationships between healthcare systems, patients and the voluntary sector?
- How can we maintain the old system while the new one emerges, without causing a financial or administrative crisis in the old?
- How can people build relationships with professionals in the face of the cultural shift towards specialisation?
- What does this mean for the hospital system and the massive PFI hospitals? The dominance of hospital spending in the NHS – which still stood at 60 per cent of spending in 2003 – may be crowding out investment in new institutions which have some chance of curing the patients, and which accounted for only four per cent of NHS spending in 2002.
- If you re-prioritised 1.5 per cent of the NHS R&D towards wellness, how would it be spent?

The purpose of our programme is not simply research, persuasion and networking – though it includes all of those. By the end of the project, we aim to put some of these linked ideas into practice. To do that, we need to build alliances around the necessary elements and draw together good practice to outline how a genuine health service would work, preventing ill-health, helping patients recover and promoting everyone’s health and well-being.

If you or your organisation share some of these aims, or if you are interested in finding out more, or if you can help us raise the money we need to launch this programme, please get in touch. We would very much like to hear from you.

Summary

The purpose of health is wellness, and health services are means towards that, and not ends in themselves.

The priority for healthcare in the nineteenth century was public health. The priority in the twentieth century was universal access to medical care for infectious and acute diseases. The priority in the twenty-first century is increasingly the management of chronic diseases, in an emerging partnership between individual, social networks and medical services. This implies some radical changes to how health is organised. But how?

It seems likely that there will be less of a role for big hospitals, and that the emerging National Wellness Service will involve more power for users, not just as individual consumers, but in groups – and more emphasis on providing information and advice to enable self-management.

The key drivers for this include public expectations and values, but also new knowledge about the social determinants of health and very powerful evidence on life expectancy and link to status, stress and social support.

This government has emphasised moving towards a consumerist model of health. But it is increasingly clear that this will not be the final destination, and that a new kind of NHS will emerge – in the tradition of public service and putting the assets of staff and patients alike to use – which:

- Focuses on wellbeing.
- Uses a partnership model of health rather than a production/consumption one.
- Seeks out new assets and resources which can pay for wellness.

Let us know what you think

This is only a draft. Your views and experience are crucial to the project, so please let us know.

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About the organisations behind this publication

The **new economics foundation (nef)** is an independent think-and-do tank that inspires and demonstrates real economic well-being. We aim to improve quality of life by promoting innovative solutions that challenge mainstream thinking on economic, environment and social issues. We work in partnership and put people and the planet first. **nef** was founded in 1986 by the leaders of The Other Economic Summit (TOES) which forced issues such as international debt onto the agenda of the G7 and G8 summits. We are unique in combining rigorous analysis and policy debate with practical solutions on the ground, often run and designed with the help of local people. We also create new ways of measuring progress towards increased well-being and environmental sustainability. **nef** works with all sections of society in the UK and internationally - civil society, government, individuals, businesses and academia - to create more understanding and strategies for change.

The Young Foundation is a centre for social innovation based in London – combining practical projects, the creation of new enterprises, research and publishing. The Foundation was launched in 2005, but builds on a long history. Our predecessor organisations under Michael Young were responsible for far-reaching innovations ranging from the creation of the Open University and *Which?* to the School for Social Entrepreneurs, as well as pioneering research on changing patterns of community and family life. Since 2005 a new team has been brought together from NGOs, government, business and academia. Our main goal is to speed up society's ability to respond to changing needs through innovating and replicating new methods and models. Our work programme has three main strands: practical action, action research and research.

About the authors

David Boyle is an associate of **nef** and has been at the heart of the effort to introduce time banks to Britain as a critical element of public service reform – since then the movement has grown to more than 100 projects in the UK. He is also the founder of the London Time Bank network and co-founder of Time Banks UK. He has been closely involved in their Clone Town Britain campaign and writes about the future of volunteering, cities, and business. He is also the author of a series of books about history, social change and the future. He is the author of *The Tyranny of Numbers* and *Authenticity*, has stood for Parliament, and edited a range of magazines.

Geoff Mulgan has been the Director of the Young Foundation since Autumn 2004. Between 1997 and 2004 he had various roles in government including director of the Government's Strategy Unit and head of policy in the Prime Minister's office. Before that he was the founder and director of the think-tank Demos, described by the Economist as the UK's most influential think-tank; chief adviser to Gordon Brown MP; a consultant and lecturer in telecommunications; and an investment executive. He is a visiting professor at LSE and UCL, and a senior fellow at the Australia New Zealand School of Government.

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