

# Improving Health Outcomes

A Guide For Action

THE CURRENT PUBLIC SERVICES FOR PUBLIC SERVICES  
MATTER TO US ALL. AT THE ROOT, THEY ARE ABOUT THE THINGS WE DO TO  
PUBLIC SERVICES IS NOT ONLY FISCAL, AND NOT ONLY SHORT TERM. NEW  
PRESSURES, SUCH AS FROM AN AGEING POPULATION  
PUBLIC SAFETY IS OF PARAMOUNT IMPORTANCE IN A GLOBAL  
CITIZENS REALISING THIS VISION – CAPABLE, RESILIENT CITIZENS, MAKING CHOICES FOR  
THE LONG TERM, PUBLIC SERVICES EXPAND INDIVIDUAL  
ABILITIES. THIS ENCOURAGES SELF-RELIANCE  
ON. DIVERSE PROBLEMS ARE ALLOWED TO FIND DIVERSE SOLUTIONS  
PUBLIC SERVICES WORK IN THE SAME WAY  
EMBRACED AND DEVELOPED

## The Health Working Group

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## About the 2020 Public Services Trust

The 2020 Public Services Trust is a registered charity (no. 1124095), based at the RSA. It is not aligned with any political party and operates with independence and impartiality. The Trust exists to stimulate deeper understanding of the challenges facing public services in the medium term. Through research, inquiry and discourse, it aims to develop rigorous and practical solutions, capable of sustaining support across all political parties.

In December 2008, the Trust launched a major Commission on 2020 Public Services, chaired by Sir Andrew Foster, to recommend the characteristics of a new public services settlement appropriate for the future needs and aspirations of citizens, and the best practical arrangements for its implementation.

For more information on the Trust and its Commission, please visit [www.2020pst.org](http://www.2020pst.org)

# Contents

Foreword	2
Introduction	3
1. The Commission's Approach – Beyond Beveridge	4
2. The 2020 Approach to Health and Social Care	7
3. The Key Obstacles to Reform	14
4. Archetypical Policy Sets	18
5. The Instruments for Change	23
Afterword – Addressing the Current Economic Context	27
Conclusion and Next Steps	29

## Foreword

The essayist Edward Abbey once mused “If the end does not justify the means, what can?” This report of the 2020 Public Services Commission Health Working Group is not intended as a contribution to moral philosophy, but it is based on the view that the right action in health service reform is one that produces good outcomes; and those outcomes are the shifts in culture, power and finance that the Commission has advocated in its interim report as the direction of change for public services generally.

The Health Working Group – like the Commission itself – comprises a range of professional experience and a diversity of political views. The Working Group’s members recognised from the outset that trying to reach consensus about specific policy options was impractical. Some members favour more market-oriented reforms to the UK’s systems of health and social care; others are inclined to accept more state directed interventions. But what all did agree on was that whatever policies or interventions are introduced to transform health and social care – whatever the ‘means’ – they should be guided towards putting citizens at the centre of a socially productive relationship that aligns power and finance with the purpose of improved national health. These are the Commission’s ‘ends’.

The Working Group’s work was made more difficult by this focus than would have been the case with a like-minded group

of individuals who simply reinforced each other prejudices. Instead of settling on the intricacies of specific means, the Working Group fashioned a guide for decision-makers, which calls on them to connect ends and the barriers to reaching them with the rationale behind policies and the enabling drivers of change. In effect, we are challenging those who will introduce health and social care reform to answer the justifying question, “Why are we doing this?”

This guide for action is not an answer; it is a process to help achieve outcomes that are sustainable and necessary if Britain’s public health and social services are to significantly improve the conditions of the people they serve. We hope this provides a useful framework for government policy-makers and for health and social care professionals, as well as for a public that must be more engaged in the journeys of public service change.

My thanks to the members of the Health Working Group and to the research team that has assisted us for their focus, tolerance, patience and commitment.

**Greg Parston**

# Introduction

The Commission on 2020 Public Services was launched in December 2008 to begin a new type of conversation about the future of public services. It brings together a diverse and experienced group of practitioners, thinkers, politicians and decision-makers to develop a progressive consensus over the case for change, and start to shape the direction that change might take. In March this year the Commission published its interim report: 'Beyond Beveridge: principles for 2020 public services', arrived at through group deliberation, multi-stranded research and a citizen engagement programme.

This next stage of the Commission's work is intended to get from the generic to the specific: to consult, listen, learn, and discover whether our approach to public service reform would make sense within the existing worlds of health and social care, education, public safety and the benefits system.

The efforts of the Commission's Health Working Group are part of this process of further developing the principles for 2020 public services. Our report starts with the building blocks set out in the Commission's interim report, which comprise three systemic shifts in culture, power and finance in public service delivery. We ask how these shifts could apply across our current health and social care system. What kind of policy changes do they suggest? How would they affect citizens' and their health?

Our report begins with a brief critique of public services, followed by the Commission's principles for reform. It then shows how participants in this project have understood and applied these principles - setting out a diverse range of policy proposals for achieving the three systemic shifts. Beneath this diversity lies broad consensus over five sets of obstacles to change: politics, institutional culture, systems management, professional motivation and the incapacities of citizens. We then set out four policy sets - showing how different perspectives might address these obstacles and help achieve shifts in culture, power and finance. The final sections offer some instruments to effect these changes, and shows why this is relevant within the current political and economic context.<sup>1</sup>

# 1

## The Commission's Approach - Beyond Beveridge

Beyond Beveridge responded to a fundamental and urgent need for a new approach to public service reform. At a time when the politics of public services has been focused on the short-term - 'what to cut' and 'when to cut it' - the Commission called for a broader perspective: a coherent, consensual approach, grounded in principle and applicable over the long-term.

The report describes the detail and implications of the Commission's vision for public services. Its recommendations respond to a broad critique of our current settlement - reflecting on system-wide problems and a set of institutional characteristics that constrain our ability to match public services to the modern needs, demands and abilities of citizens. In brief:

- Our welfare culture is **passive**, ignores the resources and collective capacities of citizens, and has failed to inspire a civic culture of reciprocity and responsibility. Our welfare culture is **static**. Too often public services mitigate problems at a particular point-in-time but underplay the early intervention, preventative

investment and 'pathways of care' that are needed to meet future challenges.

- Our welfare culture is **statist and narrow**, pivoting on the requirements of institutions and providers - not on the needs of citizens. Accountability is amassed at the political centre, leaving decision-making distant from service users and communities.
- Taken together, these failures have contributed to a system of public services that delivers **patchy outcomes** - at times doing worst for the people that need the most.

Today's public services reflect decades of investment, commitment and reform, much of it improving productivity and driving up standards for service users.<sup>2</sup> Public services can form a bedrock for societal cohesion, a means to combat inequality and an expression of our national citizenship. Now as ever, good public services are the cornerstone of civilised society.

Yet our current public services are unsustainable - both in immediate spending terms and in the face of changing demands and behaviours. Reform at the margins is not enough. That is why the Commission has called for a new approach - that respects the consensus and deep commitment to Beveridge's 1942 guiding principles, but is mindful of the need for a new model for the twenty-first century. That approach starts by getting above the services; delineating 'ends' and 'means'; and thinking from the citizen up.

During one of the Commission's recent deliberative events, one participant observed:

“(The government) have the main say, so if they’re the top people playing the strings, then we need to trust in them that they’re going to look after us because we’re the people at the bottom.”

Our vision flips this perspective 180 degrees and sees instead a society of capable, resilient citizens, making choices for ourselves, accepting responsibility and being able to make a social contribution within a positive and reinforcing social environment. These are our ultimate ‘ends’. Our ‘means’ are the steps public service reformers must take to get to this vision. Public services have always inspired innovation and creativity, but this has almost always run up against serious structural and cultural constraints. The question for the Commission has been: what shifts in thinking and practice would overcome these constraints and attain our positive and ambitious vision.

In ‘Beyond Beveridge’, we proposed three mutually reinforcing systemic shifts that would re-define the purposes, funding, delivery and consumption of public services:

- A Shift in Culture: from social security to social productivity
- A Shift in Power: from the centre to citizens
- A Shift in Finance: reconnecting finance with the purposes of public services

**Social productivity** signifies an approach in which citizens are actively involved in setting priorities for public services, and defining policy

solutions. Social productivity demands active citizen engagement with services, because achieving better social outcomes is not only about the quality of service being delivered, but also about what citizens do with them and how they create ‘quality’ and ‘value’ together.<sup>3</sup> Social productivity is about encouraging active collaboration between citizens, and capturing the social benefit from it. Public services must better engage with the vast array of resources, capabilities and relationships that shape our lives - through education, engagement and discourse.

**Shifting power** is about an intelligent transfer of political, administrative and financial power away from the centre, towards citizens and communities. We start with people and the places in which they live. From this perspective our political system would be re-balanced, with much more decision-making authority and spending discretion sitting with more local forms of government. Shifting power means thinking ‘horizontally’ about public services - away from a siloed, hierarchical and departmental model of government and towards a system where commissioning is further democratised and personalised to reflect the needs of people.

**Reconnecting finance** with purpose is a radically different way of looking at the way money is raised and spent in public services. It means clearer lines of financial accountability and more tangible links between citizens’ contributions and their benefits. It means using

### Citizens' Perspectives on Public Service Reform

A new qualitative study carried out by Ipsos MORI on behalf of the 2020 Public Services Trust asked citizens what they valued in their lives, whether and how public services meet these needs, and how they could do better in the future. The study highlighted the following themes:

- Security and Fairness - citizens are attached to the values of security and fairness, and see these values as underpinning public services. Any reform to public services must meet these values - providing a safety net and support, with processes and outcomes that are seen to be fair.
- Local Control - people are receptive to changes that would

increase local control over public services. But this must not be at the expense of national standards frameworks that allow central government to 'step in' where necessary.

- Citizen Control and Voice - individual budgets are a popular idea, but there are concerns over the 'sharp elbows' of the best placed to take advantage of them. People worried that marginalised groups might struggle to take advantage.
- Supported Choice - citizens' advisors are popular, partly because of their potential to help the most disadvantaged negotiate the complexity of services, and help people get the best outcomes.

Source: Ipsos MORI (2010) Citizen Engagement: testing policy ideas for public service reform.

existing resources more effectively over the life cycle, and mobilising a broader resource base - including informal, private and virtual resources. All of this requires a much more sophisticated approach to digital technology, which can facilitate this 'reconnection' and provide ways of providing better information and identifying citizens' needs.

The Commission believes that these building blocks can form the foundation of a new public services settlement. They are radical and, taken together, form a very different way of thinking about the way we experience, pay for, deliver and consume public services. They

also have structural implications: a different kind of delivery model and supply side; a leaner, more supple and strategic central state; a new principle of 'partnership' more concerned with fairness of social outcomes rather than with the inputs and outputs of service delivery. For all of us, this new model implies a different kind of citizenship, predicated on responsibility and reciprocity. From all of us, this new model will require greater understanding, wider participation and time to learn and develop. We believe this should be our aim for 2020.

# 2

## The 2020 Approach to Health and Social Care

In March this year the 2020 Public Services Trust (2020PST) published a report commissioned from Ipsos MORI on what people want, need and expect from public services. The report demonstrated how important health services are to the public, showing that 82% of people polled believed the National Health Service (NHS) should be a priority area for protection from cuts in public spending.<sup>4</sup> Public trust in health professionals remains high,<sup>5</sup> and the level of public satisfaction with local health services was placed at 69%.<sup>6</sup>

One recent study showed that 79% of people rate health care quality in the UK as fairly or very good. But 50% of people have little or no trust in government to improve it. <sup>7</sup>

Public awareness and ‘ownership’ of social care is not as marked. Only 46% see care of the elderly as a priority for ring-fencing. For social services, the figure is 15%. Yet these figures reflect the institutional reality of social care, rather than its relative importance. As a recent 2020PST working paper notes, ‘many people overlook society’s need for

social care...until their lives are directly affected by it’.<sup>8</sup> This is beginning to change, as a national debate emerges on the future funding of long-term social care sparked by last year’s government green paper.<sup>9</sup>

A recent ippr and PWC deliberative group found tensions around the sustainability and fairness of elderly care provision. One participant argued that “the difficulty is you’ve got people who didn’t save...(and)...people who are poor... But that’s very difficult to prove so you’re never going to have a completely fair system”.<sup>10</sup>

Within this context, the Commission’s Health Working Group started its research by asking: what would happen if we applied the thinking of the Commission across the existing terrain of health and social care? How would local health commissioners understand a shift in finance? How would social carers benefit from a socially productive approach? How would a ‘shift in power’ affect the way healthcare is delivered, or the level at which decisions on funding and eligibility are made?

We asked people what kind of interventions and policies our approach to public service reform might imply. We talked to citizens, practitioners, carers, managers and senior decision-makers within health and social care. The following are some examples of what they told us: policies that are sometimes contradictory, mostly transformational, and frequently in contrast with the way our health and social care ‘systems’ work today.

1. A Shift in Culture: from social security to social productivity

- **Social solutions for health and care problems** – Participle’s Circle initiatives have shown how the need for medical and care interventions can be reduced through socially-focused solutions. This is particularly relevant for chronic disease management and in old age, where isolation and loneliness can be the trigger for complex and mutually reinforcing health problems.<sup>11</sup> Extra-care for elderly populations is one example of how this principle could be embedded into the planning and infrastructure of long-term care.<sup>12</sup>

“isolation and loneliness need direct care, but also social networks and solidarity. It needs a local state to facilitate this.”

Doctor & Service Director, London

- **Citizens owning their own care** – remote care (including multi-channel (online, phone etc) diagnosis and consultation) has the potential to reduce expensive hospital-based care, and better utilise the knowledge and experience of patients.<sup>13</sup> 2020PST has proposed a personalised healthcare ‘front door’ that would give citizens fingertip information, access to their personal data and the ability to communicate with health professionals and social networks.<sup>14</sup> But making the most of these opportunities requires a much more engaged and educated citizenry - able to understand

and take responsibility for living healthy lives - both individually and collectively.

“the way to drive reform is by exploding the system from the bottom up. That gives you a chance of getting round built-in workforce cultures”

Senior NHS decision-maker, London

- **An inclusive relationship between citizens and professionals** – the training, work patterns and incentives of clinicians and commissioners should reflect the citizen perspective. This should be better integrated into clinical and managerial training at an early stage. Open channels between front-line professionals and citizens (eg through the ‘front door’) should be extended, and performance assessment should be based on outcome measures that better reward citizen satisfaction<sup>15</sup> and positive individual and collective social outcomes.

“the starting point is to open up the conversation. Open up day-to-day interactions, small, easy, daily things.”

Director, healthcare consultancy, UK

- **A diverse supply-side market** – a better functioning, more diverse supply-side market has the potential to respond more flexibly and effectively to a changing set of citizens’ needs and demands. This

### From Patient to Consumer to Citizen?

The interface between people and public services is constantly evolving – transforming the traditional idea of a patient-professional relationship. Are we moving from patient, to consumer, to citizen?

PATIENT	CONSUMER	CITIZEN
<ul style="list-style-type: none"><li>• Passive recipient of services</li><li>• Deferential to professionals</li><li>• Relies on access-based rights</li></ul>	<ul style="list-style-type: none"><li>• Assertive 'buyer' of services</li><li>• Utilises choice, voice and exit</li><li>• Demands entitlements-based rights</li></ul>	<ul style="list-style-type: none"><li>• Develops high value relationships with professionals</li><li>• Recognises social responsibilities</li><li>• Jointly produces outcomes-based entitlements</li></ul>

would mean policymakers should remain agnostic about whether services are provided by public, private or third-sector service organisations, and would put emphasis on the NHS as funder, regulator, manager and purchaser within a diverse market system. Stronger and more accountable commissioning at PCT and practice level (as well as through individual budgets and citizen cooperative 'clubs' for example) would be vital to making this work.<sup>16</sup>

“it doesn't matter what the methodology is - as long as you get a great, personalised, integrated care system working for people.”

Senior manager, social care association

- **Social strategies for health and care inequalities** – the drivers of health inequality are broad and often mutually reinforcing.<sup>17</sup> Strategies for reversing them must reflect this: it is not enough to increase health spending per capita. Metrics for health and social care performance must reflect this broad social context – prioritising community 'wellness'<sup>18</sup> and labour market activity, for example. A 'social' lens would also prioritise social outcomes from health interventions - so nutrition and mobility would be key.

## 2. A Shift in Power: from the centre to citizens

- **Shifting power through commissioning** – smarter, more democratic and citizen-driven commissioning is the best way to give people the means to build care around their own and their community’s needs. This would lead to personalised – and thus more productive – health and care pathways. This could be done through supported personal budgets, through single-point integrated commissioning models such as Turning Point’s Connected Care, or through a system giving citizens choice of commissioner.

“one of the biggest influences is the whole personal budget stuff. Once people get into that process knowing the available funds they have got...that’s obviously going to influence the council’s directly provided services.”

Adult Learning & Disability Services Manager, North West England

- **Integrating care through integrating budgets & regulation** – health and social care budget integration, controlled at a locality level, is key to developing the models of personalised, integrated commissioning detailed above. This would require a reconfiguration of institutional incentives and performance objectives to make collaborative working and meeting citizens’ needs more rewarding

for service managers. A flexible approach to HR policy would be essential to make sure skills are shared and recruitment is balanced.

“you have to start with integrating the regulatory framework. Separate regulatory mechanisms ensures niches and silos.”

Director of a public health initiative, London

- **A people-centred approach to institutions** – a 2020 vision must see our health and social care systems as a set of shared values, not as a set of buildings or institutions. Future primary health and care interventions should be delivered at home, and in more local community hubs (such as social clubs or pharmacies), facilitated by remote connectivity with primary health providers. This would reduce dependence on costly residential and hospital care.

“the starting point should always be: what does the problem look like to the patient or citizen?”

Politician, Westminster

- **Personalised support for citizens** – shifting power requires a different kind of relationship, in which health and care professionals work in partnership with citizens to sustain healthy lives. Barnet Council’s life-coach prototype is built on this principle – providing joined-up support for disadvantaged families through working

with voluntary or paid ‘advisors’.<sup>19</sup> Personalisation is also being encouraged through individual budgets: some local authorities are already setting targets of between 60 and 100% for individual budget provision.<sup>20</sup>

“personalisation and continuity of care are vital. Continuity of care is so important but not valued enough.”

Doctor, London

“(my personal advisor is) someone there, even if it’s just to talk to they’re still there. If there’re any problems with the house I can just come straight in instead of being held on a line or in queues”

Connected Care participant, Hartlepool

- **Respecting and supporting informal carers** – shifting power should be about better supporting people delivering basic and long-term care needs. Despite the enormous value of their contributions, estimated at around £87 billion a year,<sup>21</sup> carers are treated instrumentally within the current system, with inadequate support for their needs. Giving carers the power to manage budgets would shift power to match their responsibility - and would shift the incentives of care providers towards carer and patient needs.<sup>22</sup>

“social carers are very often below the radar, so as a means to reverse this, they could be empowered with budgets.”

NHS manager, south of England

### 3. A Shift in Finance: reconnecting finance with purpose

- **Consolidate a partnership funding principle across health and social care** – the debate on funding long-term care has brought the idea of partnership funding into the political mainstream. This could be extended to explore co-payment options across health and social care. Reconnecting finance with purpose would also encourage a range of options for citizens to contribute ‘insurance’ payments – as regular payments during working age (perhaps with tax incentives), as a proportion of inheritance tax, and by ‘unlocking’ cash through equity release schemes.<sup>23</sup>

“partnership funding is not a vote-winner, but we need politicians to take the lead.”

Leading social care analyst, London

- **Accountable and transparent public services** – a key principle for 2020 public services is transparency. In order to articulate the spending trade offs – such as those between expensive treatments and local A & E facilities – that will need to be made,

we must open up a much richer conversation through access to comparable, quality data – on public service performance, and on the impacts and direction of people’s contributions and benefits.<sup>24</sup>

“the public need to be made aware of the spending trade offs and value choices. We need to create a sense of citizenship before a new model can work”

Senior Manager, NHS body

- **A comprehensive audit of existing health and social care structures and spending** – an audit of existing health and social care structures (and working practices) should be conducted in order to flush out inefficiencies and spending duplications within the system. This should be place-based - taking a systems-wide view across health and social care.<sup>25</sup>

“we need to learn from others and create stronger communities of learning (within local authorities)”

Local authority manager, Greater London

- **Spend money on prevention and behaviour change** – recent evidence suggests that, in elderly care, every £1 spent on preventative services would save hospitals £1.20 on emergency

beds.<sup>26</sup> Action for Children and the New Economics Foundation have applied these principles to the funding of childcare, arguing that early intervention through social impact bonds could produce a return to the UK economy of £486 billion over 20 years. Evidence from the recent Change4Life initiative – a partnership between government, businesses and others – shows that engaging multiple stakeholders in long-term public health goals is already making a positive difference to childhood obesity levels.<sup>27</sup> The current system rations, not incentivises early intervention.

“long term health improvement needs to be relational; about people and talking rather than posters.”

Senior manager, social care organisation

- **Focus on worklessness** – the insidious effects of unemployment are a key driver of poor health outcomes. Health and social care reform is intrinsically linked to the trajectory of national and local economies, but integration between employment, housing and other social and health services is a key element of dealing with this at a local level. The Commission is publishing its report on the welfare and benefits system in July, which will suggest some ways the welfare system might be reformed to reflect this need.

“the health service should be about raising people’s capability. We need much closer links to employers because that links strongly to health inequalities.”

Senior academic, London

The sketches above show that the broad principles of reform and the three building blocks advocated by the Commission can lead to a range of different policy solutions. Participants in our research project have different political perspectives, diverse experiences, and differing visions of the future. None would advocate all of the interventions and policies, nor would implementation of them all be political or systemically coherent. Yet all participants were convinced of the need for reform and reassessment based on a coherent and long-term strategy. At the same time, none underestimated the difficulty of making this happen.

What emerged from our work was a strong sense that embedding real, lasting change across health and social care – whatever shape it takes – must be part of an incremental, bottom up, inclusive and gradual process. It must respect the needs of NHS managers and service providers, for whom reform-by-diktat has felt like a perpetual reality. It must open up space for local innovation, for experimentation and, ultimately, for a degree of risk that must be accounted for locally.

“at the end of the day, the NHS shouldn’t be such a top-down service”

General surgeon, East Yorkshire

In addition, any reform must respect the fact that the public are deeply attached to the notion of fairness<sup>28</sup> and the value of security from public services, as the findings of the 2020PST’s recent deliberative research confirmed. People and families with complex and multiple care needs are certainly open to the possibility of change, but this must not be at the expense of the reliability, quality and accessibility of core services.<sup>29</sup>

What this all means is that our primary concern should be about how to create the conditions for innovation and change to flourish within the broad principles of the Commission’s model and not about prescribing the precise shape these changes will take. This requires new thinking at ground level and all the way up the chain to central government.

Later in this report we set out some policy sets that emerged from the different starting points of working group members and the participants in our research. First however, we briefly set out the consensus our research uncovered regarding the obstacles to any reform.

# 3

## The Key Obstacles to Reform

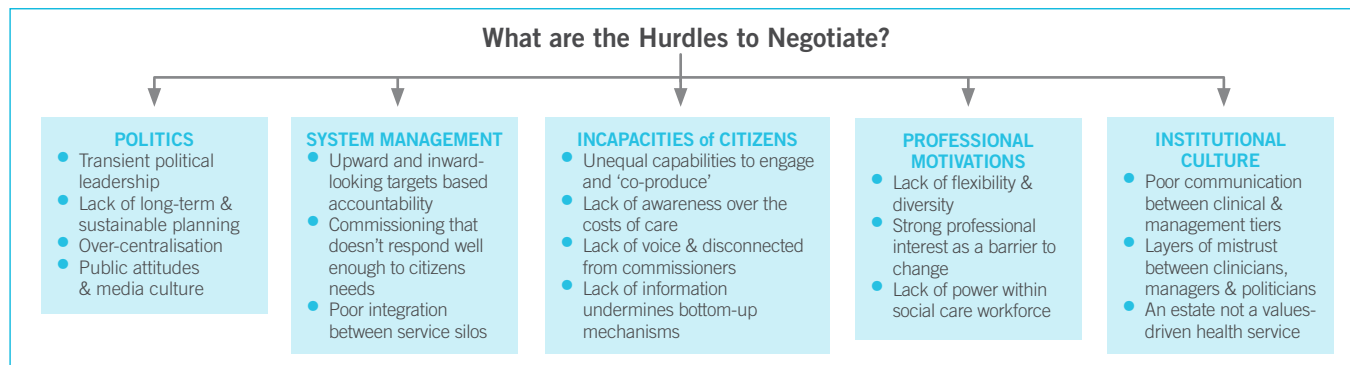
In its interim report, the Commission set out a vision for the future of public services:

‘Public services that help us to achieve – for ourselves and each other – things that we value and cannot achieve on our own. They help us become the people we want to be, living within a society we want to be a part of. 2020 public services put us in control of our own lives. They make us more secure

today and more confident about tomorrow, encouraging us to take responsibility for ourselves and for others.’

There is clearly a gap between this vision and the health and social care services we experience today. But closing the gap is not simple. It will require some overlapping and perhaps even seemingly divergent sets of reforms that will be politically difficult, and will certainly challenge current institutional and working norms.

The following diagram sets out the key obstacles stakeholders think will need to be overcome in order to unleash our three systemic shifts in health and social care. They relate to politics, institutional culture, system management, professional motivations and the present incapacities of citizens.



## Examples of International Health Systems

### DENMARK

- In Denmark most healthcare is provided free of charge by the state, but co-payment charges exist in some areas - such as dental and optical health.
- Danes have the option to take out insurance to cover the 70% charge they would have to pay towards these co-payments. There is a state option, known as Complementary Voluntary Health Insurance (VHI), or the option of taking out supplementary insurance from the private sector.
- VHI is a scheme that is used in several EU member states to help preserve the principle of state funded healthcare. The application of VHI varies in the member states. A third of Danes are currently covered by the VHI option.

### THE USA

- The Affordable Healthcare for America Act has significantly reformed the US healthcare system.
- For those not covered by a public or employment plan insurance exchanges have been created - they will be run by individual states and will operate as insurance marketplaces where customers can compare insurance plans and prices.
- Low income families will also receive subsidies if they wish to purchase their own private insurance. One of the most controversial components of the reform is the individual mandate, which introduces fines for those who do not take out insurance (with some exemptions).
- The reform also includes a tightening of regulations of private insurance companies. The most radical of these regulations is that private insurers will no longer be able to deny coverage due to pre-existing medical conditions.
- Most of the finance for the reforms will be raised in three ways; taxes on high cost insurance plans, an additional 3.8% tax increase on capitals gains and other unearned income and through fees from the healthcare sector.

### GERMANY

- The German system is called the Gesetzliche Krankenversicherung (GKV). It gives citizens a range of insurers, ranging from state, to mutual, to job-specific.
- Insurers under GKV have to accept any application, regardless of pre-existing health conditions. The insured person gets a 'sick fund', through which most health services are paid.
- Supplementary private insurance can also be taken out alongside GSK to pay for health co-payments.
- Higher earners can opt out of GKV altogether and can have full private insurance - where insurers base premiums on risk factors such as age, whereas GKV insurers charge flat rate premiums.
- In both systems the employee and employer contribute half of the premium. Relatively few people opt out of GKV, and the system has a high satisfaction rating.

### THE NETHERLANDS

- A model of 'managed competition' operates in the Netherlands. The country's Health Insurance Act of 2006 made the purchase of health insurance from a private company compulsory for those who legally work or live there.
- There are no state insurers, but the state does offer subsidies that enable everyone to afford a package. Consumers have a choice of private insurer and can change companies annually if they so wish.
- Around two-thirds of households are eligible for state subsidy, independent of the insurance company the recipient chooses. This enables the consumer to be more price-sensitive.
- For services that are not included in the mandatory health insurance package, supplementary insurance can be purchased as in the German and Danish systems.

To a large extent the obstacles reflect a broader set of problems with our current public services, as outlined in the introduction to this paper. But they are particularly acute in relation to health and social care. For example, although significant attempts have been made to shift emphasis away from expensive hospital-based care towards community and primary care interventions, structural constraints continue to make this difficult. As a recent Kings Fund report notes, ‘the pattern of community health service provision has changed little since the inception of the NHS in 1948. Specialists sit in hospitals, GPs sit in their surgeries, and community health service staff are largely peripatetic, frequently detached from both primary and secondary care.’<sup>30</sup>

“there’s no doubt that payment methods affect patients. Hospital clinicians have to write back to GPs to get GPs to re-refer to a hospital colleague, because you can’t refer between specialties within a hospital because they don’t get paid. It’s an ineffective and disjointed system.”

Orthopaedic Surgeon, south of England

For those with complex health and social care needs, the problem is often one of disjointedness; of fragmentation between people, services and needs. Vulnerable people must ‘knock on several different doors and tell their story over and over again’<sup>31</sup> – so it is citizens joining

up public services, not the other way around. The oft-blurred boundary line between people’s health needs (i.e. NHS provided and free at the point of need) and their long-term care needs (i.e. local authority provided and assessed differently) exacerbates this sense of disjointedness, and the differences in funding, delivery and eligibility between health and social care means this is a problem with massive financial consequences for families.

“In one recent local study by the Nuffield Trust, 90% of people who received social care also received secondary health care over a three-year period.”<sup>32</sup>

The relationships between political, bureaucratic and clinical management are also seen as a key source of frustration within the sectors. Frequently changing political leadership has frustrated clinicians and NHS and local authority managers, for whom stability and a sense of ‘ownership’ of the direction of travel is vital. Perhaps inevitably, clinicians often have experienced management as an over-centralised system that has skewed working incentives in different directions. Strong professional lobbies have sometimes exacerbated this sense of discord. At the margins of the NHS there is a real sense of powerlessness. Social care workers feel ‘invisible’ – though the value of their contribution (both formally and informally) is huge.

“part of the problem is that we have layers of mistrust at all levels”

A&E Doctor, South Yorkshire

Finally - and perhaps crucially - there is still a sense of disconnect between the broad drivers of health inequalities and the narrow policies proposed to tackle them. A more integrated approach is needed to reflect the multiple social factors that entrench inequality, not just a new formula for health spending within particularly disadvantaged areas. Our research - which concurs with findings in the recent Marmot Review of health inequalities<sup>33</sup> - indicates that performance indicators within the health and care sectors must better reflect social outcomes and community wellbeing.

We think that the approach to public service reform outlined by the Commission has the potential to enable new ways of clearing these hurdles. Shifts in culture, power and finance translate into a number of policy interventions that would have a tangible effect on the way health and care is funded, commissioned, delivered and consumed. Such an approach could flip existing structures, forcing funding and incentives to better reflect citizen needs, and re-shape a provider market accordingly.

## 4 Archetypical Policy Sets

The policies and interventions that would be enacted to achieve the systemic shifts advocated by the Commission would vary, depending upon the political and ideological bases of those taking the decision to do so. Even then, policies could contradict one another or at least lack coherence. Yet, from our discussions, we identified four archetypes of those whose political and ideological bases lead to a ‘propensity to agree’ on particular and specific change. Each archetype is aimed in its own way in the direction of the three building blocks for 2020 public services. We present them below as demonstrations of how different courses of action could lead to similar systemic change.

THE LOCALISTS could be expected to:

- Establish a baseline national entitlement framework, beyond which some currently provided services reflect locally determined healthcare outcomes.
- Fully integrate public spending within a locality and give spending discretion above the minimum national guarantee to more directly accountable local government.

- Establish directly elected health boards that would be voted for locally.
- Free up space for more innovation and piloting through locally-determined efficiency savings and partnership opportunities.
- Free up local NHS managers from too many centrally-set targets, making restructuring and redeploying resources (for example investment in prevention or remote-care technologies) locally-made decisions.
- Devolve commissioning budgets as close as possible to the point of need – to GPs, or service users themselves.
- Use participatory budgeting and other direct-democratic mechanisms to co-define local outcomes and spending decisions.

THE INTEGRATORS could be expected to:

- Assess community health and social care needs through more integrated front-line assessment teams.
- Commission across a wide range of public services (e.g. across health, social care, housing and employment) via integrated commissioning and procurement models - which establish community need and hold commissioners to account for meeting improved social outcomes.
- Use new technologies to create an integrated front-door for

health, care and other services - joining up access points, data availability, home-based care capabilities and better communication between peers and between peers and professionals.

- Amalgamate health and social care funding within an expanded and nationally regulated social insurance 'partnership' model
- Establish single approaches to regulation and performance management that straddle organisational boundaries and incentivise joint working and a preventative approach.

THE MARKETEERS could be expected to:

- Extend choice for individuals and carers through personal budgets - forcing a more diverse and personalised supply-side market
- Give people choice of health and care commissioners - such as choice of PCT.
- Extend practice-based commissioning to strengthen front-line clinical leadership and drive patient choice.
- Insulate the health and care market from party politics through establishing an independent NHS board.
- Tackle health inequalities through a 'health premium' that follows the poorest patients and encourages spending on prevention
- Give patients free choice of GP regardless of current geographical constraints.

- Make data on social outcomes, performance, quality and VFM available to facilitate informed patient choice.

THE RELATIONALISTS could be expected to:

- Enable patients (with or without carers) and professionals to jointly-develop personalised care plans for individuals' health and social care - using single patient identifiers and significantly more 'everyday' data sharing.
- Re-shape the workforce around social and preventative principles - meaning less need for doctors, more social carers and primary care providers, and huge emphasis on low-intensity, preventative interventions.
- Free up structural constraints by delivering healthcare in more diverse ways - in home-based and other non-NHS settings that reflect patients social lives, online and via mobile technologies
- Encourage co-operative and community based organisations to deliver basic health and social care within localities (especially social-based interventions), and on much more of a peer-to-peer basis.
- Reconfigure public health campaigning around relationships - relying on community advocates and one-to-one interaction, rather than large scale poster campaigns and top-down behaviour-shaping.

The models above are crude characterisations, archetypical policy sets that represent typically different ways of overcoming the obstacles set out above. Experience tells us that policymakers draw from each of these sets at different times, such as extending market mechanisms while building incentives to integrate, decentralise and develop rich local social and care networks.

What is important to us is not which policy set is prevalent or ideologically coherent - but to what extent the policies in question can affect shifts in culture, power and finance in health and social care. We believe that this should be the basis upon which decisions about health and care reform should be taken, and the way to encourage reforms that begin to erode the existing structural barriers to innovation and citizen-centricity.

The table on the following page suggests how this type of policy analysis could be set out.

Some of these policies are already happening within the NHS, and others are being piloted and tested within local authorities and across the independent sector. But innovation frequently runs up against structural, cultural and financial barriers. To create the conditions in which more-than-sporadic innovation can develop, we need a new kind of policy discourse. This would entail a commitment to a long-term and strategic approach to change, which is open to dealing with different patterns of risk for patients and professionals as the flip-side of innovation and improved outcomes.

POLICY SET	WHERE COULD THESE POLICIES HAVE GREATEST IMPACT?	HOW WOULD THEY AFFECT SHIFTS IN CULTURE, POWER OR FINANCE?
LOCALISTS	<ul style="list-style-type: none"> <li>● Public health and behaviour change</li> <li>● Linking health and care with employment and housing issues</li> <li>● Democratically budgeting and accounting for spending decisions</li> </ul>	<ul style="list-style-type: none"> <li>● Shifts culture by educating and encouraging citizen engagement in local service outcomes</li> <li>● Shifts power through building commissioning around whole-citizen and whole-place needs</li> <li>● Shifts finance by engaging people in spending trade-offs within localities</li> </ul>
INTEGRATORS	<ul style="list-style-type: none"> <li>● People and communities with complex and changing care needs</li> <li>● Health and care needs of young offenders</li> <li>● Remote healthcare</li> </ul>	<ul style="list-style-type: none"> <li>● Shifts culture by enrolling families &amp; communities as stakeholders in social outcomes</li> <li>● Shifts power to communities through holistic, integrated assessment and commissioning</li> <li>● Shifts finance by investing preventatively and using new technologies intelligently</li> </ul>
MARKETEERS	<ul style="list-style-type: none"> <li>● Elective surgery</li> <li>● Choice of primary health carer</li> <li>● Specific long term care provision (through individual budgets)</li> </ul>	<ul style="list-style-type: none"> <li>● Shifts culture by engaging citizens in decisions that affect them and sharing responsibility for commissioning</li> <li>● Shifts power through realising patient/citizen choice and redress</li> <li>● Shifts finance by forcing money to more clearly follow citizen choice and need through the system</li> </ul>
RELATIONALISTS	<ul style="list-style-type: none"> <li>● Dealing with loneliness, anxiety and depression</li> <li>● Long-term elderly care</li> <li>● Childcare and family - based interventions</li> </ul>	<ul style="list-style-type: none"> <li>● Shifts culture by promoting social interaction &amp; peer-to-peer health and social care</li> <li>● Shifts power by creating care relationships around people and families</li> <li>● Shifts finance by bringing non-fiscal resources and citizen agency into play</li> </ul>

For example, opening up commissioning in the three ways suggested above - through personal or shared budgets, through integrating commissioning functions, and through extending patient choice - would radically transform the health and social care market in the long term. It would force commissioners to compete to provide the highest quality personalised care at the lowest cost, force commissioners to listen to citizens needs that cut across traditional service strictures, and force individuals and families to think much more seriously about the way they use their public service entitlements.

But on the other hand, it may also increase pressure on particular hospitals or day-care centres; it might force existing providers out of business, or reduce the need for certain medical functions as a result of more integrated and 'social' spending on health problems. This would spin off into recruitment and HR policy, so professional associations, trades union and employers would need to adopt a flexible approach to skills sharing and cross-sectoral working to avoid making redundancies and damaging morale. This means that long-term and strategic leadership is especially important - in order to cope with the short-term bumps on the road to reform.

Most important, this new approach would inevitably shift a degree of risk onto individuals that is currently the responsibility of professionals. This increased responsibility is the price of greater personalisation and entitlement. For example, poor management of a personal budget would have material consequences for a person's

health and wellbeing; bad choice of commissioner could leave a patient with a poor service experience.

"I know a little girl who gets direct payments and I know her father doesn't use that money, I know all these things are audited and that, but he doesn't use that money... He goes to a separate company to get the care , but he also pays someone privately... It's a bit of a dodgy grey area."

Female, 40-64, Kent

Giving localities greater spending discretion across public services would put a high price on opting out of local democratic decision-making. This means a premium must be put on ways to enable good decision-making and to help people negotiate a future health and care market.

# 5

## The Instruments for Change

Policymakers do not have the luxury of starting with a clean slate and, in the case of health and social care especially, they must work within a structural set-up that is both culturally entrenched and publicly very sensitive. We have demonstrated how the Commission's three shifts can be a framework for long-term reform; but what are the instruments that policymakers could use to start this journey?

We argued above that our concern in the immediate term should be about creating the conditions for change, not necessarily prescribing what it should be. In this paper we have set out an analysis of the problem from the citizen and policy perspective, the case for a new approach, the obstacles this approach must overcome, and some ways in which these changes towards a new model for health and social care could be fashioned. We know that a vision for 2020 could take different forms. But what are the drivers for change in the short-and-medium term? What can policymakers, professionals and citizens do? And what would underpin a new, more educative and engaged relationship between citizens and their health and wellbeing?

We asked these questions to a range of people working to make change happen across health, social care and public services. Their perspectives

help form a set of instruments that we believe are necessary for the change we advocate.

### 1. Strategic Management

- Effective change needs strategic goals, which are jointly created, and sustained through long-term leadership.<sup>34</sup> This is key in the 'political' environment of health care reform, which encourages short-term decisions that can derail long-term priorities.
- Strategic management must be about understanding and negotiating risk - the effects of a 'postcode lottery' or managing the trade-offs required to budget effectively when drugs and treatments are costly.
- Harnessing professionalism is a key element of strategic management. The starting point here should be to ask: how can we re-cast the role of the professional, generate buy-in to change, and involve professionals in the way reform is designed and rolled out.
- Flexibility is essential - to the changing lives of citizens, patients and carers, and to the unintended consequences that would arise from democratising health and care services. Flexibility and strategy is a difficult mix, but essential to ensuring that these multiple and flexible strands of reform are pulled together coherently.

## 2. Incentives

- Getting the incentives right is key - they must be at the right level, and must be meaningful. For example, a local integrated service model (of which the 2020PST's 'more for less single place budgets' are an example) give localities the incentive to spend more efficiently by returning these savings to the locality.
- Effective workforce change also depends upon incentives that encourage health and social service professionals and managers to 'buy in' to transformation; they must have the incentive to help shape it.
- Financial incentives should link funding to its purpose. For example, a participatory budgeting process could give communities the incentive to shape social and health spending around their own needs.
- We should also be aware of the limits of incentives - and the fact that broad direction and incentive structures can unwittingly translate into a series of much narrower targets or standards at management and delivery level.

## 3. Space For Innovation

- Policymakers should prioritise creating space to facilitate local innovations, pilot projects and trial initiatives - whether they succeed or fail in the immediate term. Evidence suggests this is done more effectively at a local level, where communities and government are close together. A less central-target driven system is essential to achieving this - perhaps built around the idea of a 'system of



### A HOSPITAL DOCTOR IN A CITY CENTRE

#### How might these changes affect people like me?

- I help to shape the outcomes and incentives that drive my performance, my hospital's objectives and the decisions that affect my working life.
- The balance of my work has changed. I am more aware of the overall outcome for my patients once they leave hospital. I have better contact with the people providing primary and social care in my community.
- I support and communicate with my patients in many different ways, depending on what works for them. Using phone and email, I can care for more people and give them a better service. Communicating with patients remotely is a central part of my job, not an extra burden.
- I spend more of my time educating my patients and enabling them to care for themselves, rather than doing things for them.
- My team and I are rewarded for quality of care we provide within the resources available to us, and for the satisfaction of our patients.
- My performance is published. I can see how well I am doing compared to others, and so can my colleagues and patients.

intelligence' that mixes fewer mandated performance indicators with social metrics and bottom-up accountability mechanisms.<sup>35</sup>

- Space must be freed up for managers and professionals to shape the local workforce change they must drive through. Strategic goals over-arch the process, but local workforces should be given the opportunity to tailor to local needs and preferences within a broad outcome framework.
- Space must be created within the political process to have a more educative and engaged public debate about the spending and moral trade-offs that will be even more important to make in future. This is much more likely at a local level - making shifting power essential.

#### 4. Engaging And Enrolling Citizens

- Citizen engagement is key to reforming the health and care commissioning process. In the long term, citizens should be engaged enough and able to shape the commissioning process themselves (through personalisation or choice), or hold commissioners to account much more effectively.
- The flow of money through the health and care system is key to driving structure and practice. So where individuals, carers and communities control budgets and hold commissioners to account, the opportunity to re-shape and personalise supply markets is huge.
- Enrolling citizens as partners in social productivity will not happen without support. A recent Accenture study demonstrates a significant gap between the importance UK residents place on government



### AN ELDERLY PERSON WITH CHRONIC NEEDS:

#### How might these changes affect people like me?

- I own my personalised care plan. I helped design it so that it's built around my needs.
- My family and I were involved in choosing the services and providers that support me, based on simple information about what they offer and how good they are. They all talk to each other and know what my family and I need.
- I get support at home when I need it, by phone and on my computer.
- I can see all the information about me that's used by the providers that support me. I can add to my information and let my family see it if I want to.
- I can rely on a network of peers, community members and carers and get in touch with them quickly and easily so I don't have to feel lonely or isolated.
- I feel secure because I can pay for my care and won't have to sell all of my assets to cover the costs. I have contributed a portion of 'partnership' funding through insurance contributions during my working-life.

assisting them in taking more responsibility for their health and what they actually experience.<sup>36</sup> Closing that gap means providing more of the knowledge and tools people need to improve their own health.

- Remote control is central to reform. People should be able to interact with their healthcare and other public services in ways that go with the grain of their everyday lives – interacting remotely with clinicians through a range of digital channels (e.g. tele-health, online consultations), online ‘self-service’ access (e.g. self-diagnostic and, in some cases, self-prescription tools), accessing services in currently non-NHS settings; benefiting from more awareness of the value of healthy living and active lifestyles.

#### 5. Outcome-Driven Commissioning

- The way health and care services are commissioned is central to the social outcomes we get. We should start by delineating our current definition of commissioning, making sure that commissioning, procurement and contracting are distinct and properly understood.
- Commissioning services in health and care should be about first understanding the real needs of communities - across service boundaries. Embedding a principle of community-led peer research would drive better understanding and engagement of communities. This would enable efficient procurement of appropriate services, so that contracting better matches outcomes to needs.



#### **A MOTHER WITH A DISABLED CHILD:**

##### **How might these changes affect people like me?**

- I work together with a public services advisor and primary health care providers to put together the best package of care for my child.
- I am a member of the team that makes the decisions on where public money is spent in my area. I can hold my service commissioner to account for the outcomes I helped to define.
- Respite care and reliable support are available through an organised network of informal carers and community members. And I have access to much more information, support, peer-to-peer and expert communication online.

- Contracting for social outcomes should thus be the end-point of an integrated and rigorous commissioning process. Variance in local outcomes would reflect a much better understood variance in community need in different places.

#### 6. Knowledge Transfer

- Opening up space for local innovation is one side of the coin. The other is a network that enables rapid sharing of new experiences,

research findings and day-to-day issues. This must be 'horizontal' - at the level of people and organisations (including those outside of the NHS and local authorities). Innovation should involve civil servants, but not always be aggregated up to central government level.

- Embedding a culture of innovation and experimentation is not only a bottom-up process. Health and social care professionals and managers need new development tools, case studies from which to learn and opportunities to engage with other innovators from outside of health and social care. Innovation units could be embedded within PCTs and be part of strategic planning with local authorities.
- Knowledge transfer within hospital wards and in care homes can facilitate what the NHS Institute for Innovation and Improvement has called a 'social movement approach' to change - bottom up, non-prescriptive, evidence-based.

## 7. Sequencing

- Research prepared for the 2020PST by Ipsos MORI shows the attachment of the public to fairness and security in public services. When change is resisted, it is often because of a perceived challenge to these ideals (though we should recognise they are often undermined already in our public services). So reform must be based on a strong narrative that supports fairness and security, and must begin within non-core services and in a localised context.

- Getting the tight-and-loose question right is key here. Core minimum health and care entitlements should be guaranteed by a national framework, with more peripatetic services shaped by local contexts and needs. Distinguishing these entitlements across a broad area is perhaps the most difficult question of all.
- Our research clearly showed that embedding change must be done incrementally, as part of a staged programme - not through large-scale top-down system engineering. The 2020PST has called this 'variable geometrics': the idea that different places and organisations will necessarily reform at different times in different ways. This makes it essential to take steps when it is possible to - not to wait for a perfect, system wide moment for change.

The seven instruments above offer a way of starting to address the obstacles explored in chapter 3. They are interdependent and should be mutually reinforcing. Some have more relevance than others at particular levels and times of change. These instruments comprise the final components of our decision-making framework. Frequently, proposals for public service reform embrace *means*, such as these instruments, in the hope of achieving unidentified *ends*. We assert that the connection of these means to ends is a crucial part of the assessment of their value.

# Afterword: Addressing the Current Economic and Political Context

One of the paradoxes of the UK's fiscal crisis in 2010 is the political clamour for deep cuts to public spending, amidst political promises to maintain health spending increases in real terms in each year of the (current) parliament.<sup>37</sup> As the poll figures mentioned in section 2 suggest, the NHS apparently is electorally sacrosanct. But as the IFS observed after the 2010 budget, NHS exemption from spending cuts will mean much deeper cuts elsewhere.<sup>38</sup>

The societal challenges ahead, such as the ageing population (which NESTA estimates will cost an extra £300 billion by 2025),<sup>39</sup> question the economic sustainability of even a protected health service budget. In an earlier analysis for the 2020PST, Professor Howard Glennerster noted that unmet demand in future could require an 'additional 4-6% of our GDP over the next twenty years'.<sup>40</sup>

The Commission on 2020 Public Services has consistently argued that meeting these challenges over the long term will require more than squeezing efficiencies from the current health and social care system, and more than simple ring-fencing of existing departmental budgets. And for fundamental decisions to be made about these sectors, a broad and inclusive debate is needed - at a much more local level than is

currently the case - that asks what we want and need from public services as a whole.

In a new paper for the 2020PST, Professor Christopher Hood argues that, in the face of the huge demand and fiscal challenges ahead, three scenarios are possible: a 're-engineering of recent reforms', radical 'system re-design', and an 'East of Suez moment' – withdrawing the state from some of its existing activities.<sup>41</sup> In reality, policymakers will have to borrow from all three scenarios, combining an efficiency squeeze with creative ways of meeting citizens' needs differently.

The seven instruments above can provide tools for this longer-term process. But what of the current financial questions? Can our three shifts precipitate 're-engineering', 'system re-design' and 'East of Suez' moments that would be legitimate within the current constrained fiscal context? Emerging evidence gives us reason to believe they could - saving money over the long-term by reconfiguring health and care services around preventative, low-intensity home-and-community based interventions and by broadening the resource base.

For example:

- Recent evaluation of the **preventative social care**-focused Partnerships for Older People Projects (POPPs) showed an average saving of £1.20 in NHS emergency bed spending for every £1 spent on the programme.<sup>42</sup> Recent research by Turning Point has

suggested their integrated approach could save over £2.50 in the longer term for every pound spent on the programme.<sup>43</sup>

- A recent report by Dr Foster and Healthcare at Home identified potential national savings of more **home-based healthcare** as between £540 million and £1.2 billion across long term and ACS conditions, enhanced support discharge, specialised services and end-of-life care.<sup>44</sup>
- NHS Direct estimated in 2009 that it was 'already saving the health service £70 million a year by creating £220 million of direct benefits' such as through **reduced A&E and GP appointments**.<sup>45</sup>
- A recent Kings Fund evaluation of the case for a **partnership funding** model for social care estimated a 50% increase in the cost of care under the current system by 2026. Their proposed match-funding partnership model would share the cost between individuals and the state, injecting new funding into the system and cope much better with unmet demand in future.<sup>46</sup>
- The Institute for Government's David Halpern has recently shown the potential of better mobilising the **social and informal resources** that people have - what he calls the 'hidden wealth of

nations'. One example is nurse-family partnerships, which US evidence suggest show 'a payback to the public purse of four times (their) cost'.<sup>47</sup>

- Recent efforts to **integrate budgeting and commissioning** within localities have suggested big efficiency savings. For example, Croydon estimate a saving of up to £61 million by 2023-4 through integrated early assessment. Bradford estimate that providing a 'single point of contact' for people leaving hospital care and providing more community support could save around £1.8 million.<sup>48</sup>

We believe that long-term changes of the types described in this report, begun immediately, can help mitigate the economic pains of which the new government warns. Short-term fiscal reductions in health and social care that are not connected to more fundamental change will not work given the demographic trends that lie ahead.

## Conclusions and Next Steps

At the outset, this report asked: How would the principles of the Commission on 2020 Public Services apply across our current health and social care system? What kind of policy changes would they suggest? How would they affect citizens' and their health? And we have remained concerned about the extent to which our approach chimes with the everyday lives of people working in the NHS, local authorities and beyond.

We believe our efforts provide some tentative answers to these questions, and a practical framework for helping people within different parts of the system make strategic and coherent policy decisions.

What we have seen is that the three systemic shifts advocated by the Commission offer an effective way of making sense of reforms that could meet the health and social needs of citizens, and the aspirations of people working to deliver services. What also comes across strongly is that systemic shifts in culture, power and finance can prompt diverse (and sometimes even contradictory) policy ideas. This is both a strength and a drawback of our work: giving flexibility of means to reach progressive ends but also making it difficult to propose a set of consensually agreed 'next steps'.

That said, it is clear that immediate attention can be focused in areas where – regardless of politics or ideology – there seems to be robust agreement of the need for action:

- an extension of integrated preventative care,
- a refocusing of local commissioning on improved health and social outcomes; and
- a radical reconfiguration of services in support of more home-based care.

None of these changes can be done easily or quickly; but they all need to be done. Other, larger changes will be driven by policy and economics and these will need careful thought, deliberation with the public and clear connections to intended results.

For these reasons, we present our report principally as a framework for decision-makers - offering ways of understanding potential directions of reform and the political and ideological starting points that underpin them, as well as a set of instruments that can start to unleash change. This is where we think the Commission's approach is most useful: in helping to frame and make difficult decisions within the context of contentious political debate, and in forcing a comprehensive and coherent approach within systems that are often wedded to ways of working that remain entrenched in the 'sectional interests' that Beveridge attacked over 60 years ago.

How should decision-makers use our decision-making framework? Two questions are key:

- *Do our proposals for change start and end with three systemic shifts?* Shifts in culture, power and finance should be both the start and

end points of the policy development process. They are a tool for designing coherent policy ideas; but also signals as to the progress and effectiveness of these ideas.

- *Do all the elements connect?* The framework provides a way of thinking systematically about needs, problems, solutions and drivers. Decision-makers should ask: do all the pieces add up? Are we seeing all the elements of the problem? Have we considered the impact of potential solutions across the whole system?

These questions need examination and debate amongst policy advocates, within the professional communities of health and social care, and with citizens, patients, carers and the public at large.

Too often, public service changes aim too narrowly at overcoming specific obstacles or are driven by blind ideology. The connections to ends – to the shifts in culture, power and finance – are vital to creating

a system of health and social care that emphasises social productivity, citizen-centricity, financing connected to purpose and that enjoys the support of all who are part of it.

We want this report to provide a spark for an invigorated discussion and debate on the direction of reform within the National Health Service, local government and beyond. Shifting established structures and ingrained patterns of working is difficult - and impossible without the engagement and support of the people who work to deliver services and manage the process. In 2010, the fiscal crisis is dominating national debate on public services. Questions of what to cut, when to cut it and how to squeeze out more efficiencies are mainstream. Yet this discourse risks ignoring the expertise and capacity for innovation already in the system, and risks forcing short-term spending decisions that would undermine more fundamental structural reforms in the longer term.

We have consistently argued that taking short term action without a serious debate on what kind of society we want and what type of

### Using the Working Group's Decision-Making Framework



public services that society requires would be disastrous. Decisions taken now must be consistent with long-term principles, and must – over time – pull in mutually reinforcing directions. We believe that this report can help entrench a longer term perspective within health and social care, and provide a framework within which to develop agreement over how best to achieve a vision for 2020 public services.

## Endnotes

- 1 During this project we solicited the views of a wide range of health and social care experts and observers. Among those involved were John Benington, Stephen Burke, Julian Denney, Nigel Edwards, David Furness, Martin Green, Judy Hargadon, Richard Humphries, Ron Kerr, Richard Kramer, Gavin Lambert, Lord David Lipsey, James Lloyd, Caroline Marsh, John Procter, Katherine Ward and a Yorkshire-based deliberative group of clinicians. We also benefited from a number of anonymous contributions.
- 2 See for example a recent article from Nick Timmins, 'How New Labour Succeeded with NHS Policy' Financial Times, 13th March 2010. See also Uberoi, V. et al (2009) (eds) 'Options for a New Britain' London, Palgrave
- 3 Two concepts are particularly useful here. The first is the idea of 'public value'; the second the idea of co-production. See Moore, M.H. (1995) 'Creating Public Value: strategic management in government' Boston, Harvard University Press; Cole, M. & Parston, G. (2006) 'Unlocking Public Value' New Jersey, John Wiley & Sons and Horne, M. & Shirley, T. (2008) 'Co-Production in Public Services: a new partnership with citizens' HMG, Cabinet Office - available at [www.cabinetoffice.gov.uk/media](http://www.cabinetoffice.gov.uk/media)
- 4 Ipsos MORI asked the question: 'Which two or three, if any, of the following main areas of public spending do you think should be protected from any cuts?' See Ipsos MORI, Buddery, P., Kippin, H. & Thompson, J. (2010) 'What do People Want, Need and Expect from Public Services?' London, 2020 Public Services Trust p.40
- 5 See Royal College of Physicians & Ipsos MORI (2009) 'Annual Survey of Public Trust in Professions' available at <http://www.ipsos-mori.com/researchpublications/publications/publication.aspx?oltemid=1305>
- 6 Ipsos MORI et al (2010) 'What do People Want, Need and Expect from Public Services?'
- 7 Accenture (2010) 'Measuring People's Impressions of Health Care' London, Accenture Institute of Health & Public Service Value p.39
- 8 Kippin, H. (2010) 'Social Care in 2020: what are the challenges ahead?' London, 2020 Public Services Trust
- 9 This was reflected in sharp party political differences on the subject during the general election campaign.
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## Acknowledgements

Many thanks to health working group members, members of the Commission on 2020 Public Services, interviewees and participants in the research and preparation of this report.

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The 2020 Public Services Trust

is a registered charity in England and Wales (no. 1124095)

Published by the 2020 Public Services Trust, July 2010

2020 Public Services Trust at the RSA

8 John Adam Street

London WC2N 6EZ

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ISBN 978-1-907815-08-9 Improving Health Outcomes – a guide for action Paperback

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