The Health Service -

Protecting Values

And Achieving Value

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It is common form in a speech to begin by creating some point of identity or empathy with your audience. An initial flattery, a pleasant anecdote or some other gesture recognising or commending the work of the audience or the business of the Conference is the usual vehicle.

Because it is so common, you would perhaps find it trite if I were to open my remarks in such a manner. The truth is that Health Service managers are a difficult audience for a public representative - particularly one who has not served in a Health Department. I do not think that it caricatures the position too much to suggest that politicians and health service managers hold one another in squinting regard.

Depending on the politicians' position, the Health Service manager is variously a bureaucrat, insensitive, ruthlessly efficient, inefficient, a Minister's lackey, an empire builder or a service destroyer. Politicians on the other hand may be regarded by managers as ill-informed, uninterested, emotive, easy meat for lobbies or special interest groups, irrational in their representations to managers and inadequate in their representations to Ministers.

It is not my intention to concentrate on softening any of those images as such. Rather I want to face up to that unsure relationship between politicians and managers. That uncertainty is not some recurring personality clash between rivals for influence. Rather it reflects a confusion, inherent in present arrangements, about our roles in respect of policy formulation, administration and accountability. These functions are not as well identified and defined as they could be. This in turn means that the allocation of relevant responsibilities tends to be more blurred than is necessary. Whatever picture we might have of our own responsibilities we each find ourselves

pushed into "twilight zones" with managers sensing that they are being brought into the realms of party politics or politicians choking on detailed technical and management considerations. While I am not advocating strict and remote demarcation, I am convinced that the interface between political accountability and management responsibility must be tidied up in a way that allows or ensures that both functions can be better discharged.

Many on the right of the political spectrum would agree with my view that there is a clumsy blur at the government/management level of the Health Service. However they tend to draw the conclusion that this highlights the inefficacy of state involvement in health service provision. They argue that present structures create bureaucracy and tax burdens and fail to deliver "real accountability". For them "real accountability" is market forces. Their way of clarifying the blur is to remove the political factor from the equation and to replace it with privatisation, deregulation and competition. They seem oblivious to the fact that they would be removing the fundamental social dimension to health policy. But then some, like the Prime Minister, do not believe in "society" and therefore do not believe in social considerations.

This attitude poses a basic question about the purpose of a health service as well as about processes. It reminds me of an instance when, a number of years ago, I heard a senior official in Aer Lingus remark that if his company did not have to fly planes then they could make a healthy profit. Presumably if health services did not have a social responsibility to provide treatment and care to all in need of these, then they too could be very profitable.

That such views enjoy their present ascendancy means that the old consensus on health services has fractured. Those of us on the left of the political spectrum who believe in comprehensive social provision of health care must have a more meaningful response to this than just defending the status quo or denouncing "rationalisation". Rather we must reaffirm the basic principles of social provision, reappraise current health service procedures and determine that the service be as effective and as efficient as possible.

It is in determining effectiveness and delivering efficiency that we come to the interface between political accountability and management responsibility. The questions of what we want to provide in health services, to whom this is to be provided and how we pay for this are socio-political questions. These must be determined through the political processes informed by the views of those intimately involved in providing health care. The political emphasis therefore must be on outlining the requirements of effective health care provision.

There is obviously a political interest in seeing that such effective programmes are delivered with minimum waste of public resources, minimum frustration to patients and proper working conditions for those in the service. While there is a political interest in these matters and they can be covered in an outline of an effective health service, they are not matters at which politicians are very good. For a whole series of reasons, politicians are not up to those jobs. These issues must be the task of those who have managerial skills and responsibility and those people best do their job in an environment which enables and encourages them to be innovative and reforming as well as accountable.

Such a scenario for management will lead to suggestions from the right that there will be health service barons indulging themselves at the taxpayers' expense. Others on the left might fear that managers, if allowed too much scope, will reduce provision and inflate administration. I am aware of such dangers, but they are just as real under more direct political control. There are better ways than a Secretary of State to check any such tendencies.

Maybe I am a rarity on the political benches but I have no axe to grind against technocrats as such. In my early political career I sought the creation of the Northern Ireland Housing Executive, taking housing administration out of the hands of local politicians and instead handing it over to a free standing agency charged with delivering housing programmes as approved by parliament. I believe that this structure has greatly enhanced our housing situation, allows for a much wider understanding of issues of funding and policy in relation to housing and provides for an input by local representatives but does not depend on it. Some criticise it as technocratic; I say it works and it allows those with responsibility inside the organisation to manage. It is not perfect and is due perhaps for timely reorganisation but that is not an argument against giving a public agency room to carry out its mandate. I believe in harnessing the skills and motivation of technocrats for approved social ends.

Similarly as a Euro MP I come across a lot of criticism about Brussels bureaucracy and the Euro-technocrats. The fact is that these agencies and officials have been an engine for progress, ideas and common sense in relation to a whole range of detailed matters which would otherwise be neglected or unresolved.

It will hardly surprise you that I have come across allegations about bureaucracy in the Health Service with well carpeted administration buildings occupied by overpaid service spectators. It might surprise you to hear that I do not particularly subscribe to that view. If we are to enjoy comprehensive health care and direct resources to that end we need management in all its processes. The fact is that in terms of proportionate health budget consumption the administration costs of the NHS are less than half of those in France and about a quarter of those in the United states. Indeed management costs here have been reduced alongside the various Cost Improvement Programmes relating to care provision which have concerned many of us in recent years. (Indeed those Cost Improvement Programmes would indicate an over-active management in the eyes of some people!) The fact that the UK through the NHS enjoys on aggregate terms possibly the best health care provision in the European Community even though it spends proportionately less than most other EC members is not something that health administrators should be reticent about.

This point is not to be read simply as a testimony to the quality of management available in the Health Service here. It also highlights that comprehensive social provision of health care is efficient. While the UK has better health service provision than other EC members while spending less as a percentage of national output, it has to be remembered that within its spending on health, it has a greater contribution from public expenditure than other countries. This points to the value and efficiency of public sector provision for health.

Those who advocate "rationalising" health services by rolling back public sector involvement should consider that point. Surely providing a comprehensive service, accessible to all, allowing for sensible planning and economies of scale is a very rational way of optimising total expenditure

on health?

But we do have to re-appraise the health service as we know it. Those of us on the Left must accept that the leviathan created in 1948 is not necessarily the most appropriate structure in modern circumstances. The NHS as created by Bevan has almost an iconic standing in the eyes of many of us. It is valid however that we review whether existing arrangements provide for the best translation of the social values behind the Health Service into modern reality.

The fact is that some considerations which shaped the NHS no longer apply. Obviously its novelty and the need to ensure its proper introduction and development were conditions making for centralism that no longer apply. Its overall structure also reflected industrial and economic processes of that time which are now obsolescent. The Fordist structure of mass production of a uniform product to a mass market is being replaced by "Post-Fordist" processes. Production is much more market sensitive, markets themselves are much more diverse as are outlets serving them. While industry is centralising some processes, there is a trend also towards decentralisation, greater market sensitivity and greater managerial autonomy with the central firm concentrating more on strategic planning and less on administrative detail. Such changes clearly pervade our economic culture making for more consumerism and it would be wrong to insist that the Health Service should not assimilate these trends while at the same time ensuring the values which inspired the health service. If we opt to resist all these trends then we will only serve to render the Health Service more remote from the aspirations of the community which it is supposed to serve. By doing this we would only enhance the climate for privatisation.

Such a re-appraisal of existing structures would only be worthwhile if there is a clear commitment to continue with the values inherent in social provision of a comprehensive health service. Rather than pleading that the NHS is safe in their hands while at the same time speculating on the value of rolling privatisation, the government could help things a lot by declaring whether or not they subscribe to the values of a comprehensive health service.

These values include equality of entitlement and access to health services, equity of treatment with service matching needs and services free at the point of delivery. Achieving those ends requires efficiency, making the optimum use of resources and quality in standards of service delivered ensuring effectiveness in achieving these objectives. In determining effectiveness we have to be sensitive to individual and local needs as well as societal and national considerations.

This is entirely consistent with the Royal Commission's outline mission statement of 1979. If we are to fulfil these objectives we have to adapt present structures. The political dimension must be to secure a consensus around those values and around socially funded, comprehensive services as the method of achieving them.

Such a consensus is necessary if those managing delivery of these services are to enjoy the scope to do their job well and not be caught in a working climate subject to sharp political change. I think that it is wrong that health service managers can find themselves having to deliver savings not to provide resources for new developments but to facilitate tax-cuts for the wealthy. But I would also regard it as wrong if managers under a different government found themselves having to engage in expenditure in

non-priority building programmes instead of purchasing new equipment just because the building programme provides more employment for the money. Any savings which can be achieved in public expenditure or any creation of employment are to welcomed as dividends in a well-managed, efficient provision of public health care but should not in themselves determine the allocation of resources.

Creating more managerial autonomy in the health service requires greater devolution to local and regional authorities. Ensuring greater public accountability requires de-centralisation also. National government and a Parliament absolutely congested with business is not a practical means of accountability as there is not the proper facility for meaningful scrutiny. There is also a deficiency in the health service in terms of information systems to provide for more realistic accountability or monitoring for strategic planning purposes. But even if that was to be resolved, a Secretary of State and his/her ministers, parliamentary question time and the Social Services committee would still provide little more than token accountability.

The question of funding is obviously crucial. Clearly I want the service to be funded from taxation. However, it would be useful to consider alternative methods of tax-based funding. As a way of enhancing accountability and public understanding and marking the consensus around the health service a hypothecated tax is worth looking at. This would imply a basic continuing guarantee of resources to the health service. It could also help to secure greater sensitivity to the need for efficiency in the expenditure of those resources.

Of course matters such as pay awards would also potentially be subject to overall national economic policy. Therefore the pay issue could not

be left as the joker in the pack as far as managers of health budgets under such a system would be concerned. Even with hypothecated taxation there will be the residual need for supplementary funding from the general tax haul. The pay element of health expenditure could be linked to the general taxation source. I suggest this not just to allow for better planning by health authorities. But also because as someone who believes in a minimum wage and finds some wage levels in the health service offensively low, I believe that ensuring a socially decent wage in the health service should not have to create dilemmas for health authorities between workers and patients.

Another consideration in moving towards this earmarked or hypothecated tax is the possible implications of greater tax harmonisation in the EC. Such a system would pre-empt any longer term developments which might otherwise squeeze tax revenue resources on which the health service has been dependent. It could also set a useful model which some of my colleagues in European Socialist parties could invoke for their countries.

The allocation of funding among health authorities would pose further problems. Given regional economic disparities, it would contradict the nationally set values if authorities were to rely only on the indigenously raised hypothecated tax. The RAWP or PARR formula, as it applies here, must be fine-tuned to take greater account of morbidity at regional level. Economic and social deprivation are factors which contribute to shaping health patterns and health service demand in the regions. Demographic balances such as those between rural and urban areas are another factor to be considered. So too there are some inequalities in terms of historic capital investment patterns when comparing regions which should be addressed. Accommodating these factors alongside paying regard to general population, staff and facility levels is hardly an impossible task.

If health authorities are to be able to use the guarantees of funding which would be consequent on such a change to ensure better planning and earlier implementation of plans they will also need to monitor their own efficiency patterns and ensure optimum use of their resources. I have no arguments against value for money. It is to ensure value for hard-earned money that I believe in comprehensive social provision therefore I also have to support the judicious management of resources.

Securing earlier implementation of plans requires that authorities would be able to use their funding gurarantees. One way of allowing more front-loading would be to take loans from a Health Service Development Fund which again would be funded from general taxation. Such a facility is in keeping with the principles and of public funding & general regional equity but also provides for flexibility and management initiative. With no principled objection to allowing flexibility and initiative I would not rule out the notion of regional authorities or their sub-agencies purchasing services from or selling them to other regional authorities or sub-agencies. There are many conceivable circumstances where to do so would serve to provide the optimum use of resources in given areas. Such facility could include ancillary, administrative and technical services as well as certain elements of direct health care provision.

You will understand that such a facility would have to be circumscribed by conditions relating to the standard of service which anyone in any region should be able to expect and regard for the working conditions of service employees. This facility would not extend to using private contractors.

Such flexibility would allow health authorities more scope for innovation or targetting particular local or regional factors. It would allow management to be more innovative, practice more leadership and emulate the best efforts of other regions. It would free politicians from the impossible

chore of inadequate and overdue fact-finding on administration, to concentrate instead on more strategic considerations in relation to health policy.

For politicians to buy this and sell it to their followers would require clear guarantees about local accountability. Local community representatives would have to be sure that they are sharing in the new autonomy. Professional staff and health service workers would have to be confident that they are participants in the regional health care team. There would have to be more identifiable methods of monitoring the performance of authorities. Equally there would have to be an accessible and practical means of complaint or grievance-raising for the consumer of the service.

These might be irritants to some of you as managers but they would be essential ingredients in any realignment of responsibility in relation to the health service. If we are to have more rational administration we must also have more rational accountability. If we are to truly provide for more regional leadership in health service provision, we must ensure that we have a proper team atmosphere in those services. We cannot give management the room which it needs to manage resources efficiently and effectively if we do not also give room for local representatives, staff, professionals, and consumers to make their contribution. Such an ethos is consistent with the purpose and principles of a public health service. It should be taken as an inevitable environmental factor for health service managers whether you would regard it as an occupational hazard or benefit. I do not think that such accountability would be a burden any more than providing greater autonomy would be.

I do not pretend that I have a "new deal" written out to cover all these points. My lack of detailed knowledge of the health service would not

permit such an exercise. However, as someone committed to greater regionalisation in all matters, committed to the values of comprehensive social health care, committed to ensuring value for tax-payer's money and recognising the changes which we are experiencing in some of our economic culture, I do believe that we have to take our thinking along such lines.

We must restore consensus to health policy by renewing values as well as pursuing value. We can allow for diversity without creating disparity if we provide for greater flexibility in public health services. We can ensure more effective accountability, staff motivation and consumer responsiveness by progressing from the over-statist structures which we now have. We can give managers more scope but it might mean more pressure. The question is "could they manage it?"