

The Bevan Commission
in partnership with
1000 Lives Plus



Improving Healthcare White Paper Series - No. 3

Are Bevan's principles still applicable in the NHS?

Based on the 'Back to Bevan' seminar held in Cardiff
and St Asaph in January 2011

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1000 Lives Plus

1000 Lives Plus aims to improve outcomes and drive quality improvement in Wales through reducing harm, waste and variation in the system and improving the overall experience of care.

It was launched in May 2010 and is one of several national programmes which form a five year strategic framework for NHS Wales.

As a national programme, it is committed to enabling rapid acceleration in the scale and pace of sustainable improvements to give every person in Wales reliable, high-quality care every time.

Meeting this challenge is central to improving services and cultural transformation in Wales. It requires exceptional leadership and commitment to ensure continuous improvement is integrated into everyday working.

Through a series of work streams 1000 Lives Plus takes forward the standardised improvement methodology, use of evidence-based interventions and measurement for improvement introduced by the 1000 Lives Campaign and Intelligent Targets work.

It supports all health boards and trusts to set and achieve appropriate targets for the reduction of harm and hospital mortality through the reliable implementation and spread of evidence-based interventions and the tracking of outcomes.

1000 Lives Plus currently delivers several evidence-based areas of work to ensure better health outcomes, a better experience of care and better use of resources. New areas driven by population-need will continue to be introduced to enable innovations and local developments, whilst also embedding improvements across Wales.

Further information is available at www.1000livesplus.wales.nhs.uk

The Bevan Commission

The Bevan Commission is an independent, expert advisory panel which provides the Welsh Government with advice on the reform of the NHS in Wales and related matters. It was established in July 2008 to coincide with the 60th Anniversary of the National Health Service and takes its name from Aneurin Bevan, a Welsh MP and the Minister for Health who founded the NHS in 1946.

The Bevan Commission supports the aim of establishing a "world class" healthcare service in Wales, through an integrated system of healthcare delivery. To this end, it advises on how to successfully create a health service that is publicly owned and publicly provided; rooted in an ethic of care, rather than competition; for the pursuit of health as well as treatment of illness.

As part of its work, the Commission scrutinises the relevance of emerging health issues and ideas, assesses opportunities for speedier improvements in health and social care provision, and advises on rebalancing and streamlining the health and social care system within Wales, ensuring the patient is the focus of healthcare.

Video highlights from presentations at the 'Back to Bevan' seminar are now available online at <http://tinyurl.com/68nggw3>

Are Bevan's principles still applicable in the NHS?

Background

In December 2008, Edwina Hart AM OBE OStJ, the Minister for Health and Social Services, convened the Bevan Commission, to offer advice on ensuring the NHS remained loyal to the principles established by the founder of the NHS, Aneurin Bevan. The Bevan Commission has since become an important independent advisory body, addressing the needs of Wales and the concerns of the Minister.

The Commission's initial focus was on the principles underlying Bevan's creation of the NHS. It was difficult to find a single authoritative statement of the founding principles, but through discussion, the Commission created a list both of the principles it believed were at the root of the 1948 NHS model, and others which were compatible with the original vision and reflected the situation in the early 21st century.

The Commission discussed various formulations of the core founding principles and agreed that in the following format these remain valid:

Comprehensive treatment, within available resources
Universal access, based on need
Services delivered free at the point of delivery

In the 60 years since the foundation of the NHS, circumstances have changed and it was felt further principles implicit in the original intention now needed to be made explicit. The result was the eleven Bevan Commission Principles that were suggested as continuous guiding principles for the NHS.

The Bevan Commission Principles

Universal access, based on need
Comprehensiveness, within available resources
Services free at the point of delivery
A shared responsibility for health between the people of
Wales and the NHS
A service that values people
Getting the best from the resources available
A need to ensure health is reflected in all policies
Minimising the effects of disadvantage on access and outcome
A high quality service that maximises patient safety
Patient and public accountability
Achieving continuous performance improvement across all
dimensions of healthcare

In January 2011, the Bevan Commission and the Welsh national programme for healthcare improvement, 1000 Lives Plus, convened an event called '**Back to Bevan**'. Key speakers from England, Scotland and Wales were invited to examine the principles identified by the

Bevan Commission and compare them against the experience of working in the NHS in each country. In the context of dramatic changes to NHS structures in England, and constraints on expenditure in all three countries due to the economic situation, the question was asked 'Would the NHS be recognisable now to its founder?'

The following paper is based on the presentations made at Back to Bevan. The content is separated into analysis of the situations in all three countries, followed by some conclusions that link the challenges NHS Wales needs to be aware of as it seeks to live up to its principles.

Back to Bevan

For over sixty years the National Health Service has been a model of healthcare provision that many nations and healthcare experts across the world aspire to. However, with increased financial and political pressures, the future for the NHS is the subject of much debate, even to the point where questions are asked whether it can continue to function given the demands placed upon it.

Looking to the future of the NHS, it's important to understand the journey the NHS has been on, from its birth in the shattered infrastructure of post-war Britain, to the many economic and social challenges it now faces.

The NHS was founded in the period of financial austerity immediately after the Second World War - a time of new government and new political agendas. It came into existence despite hostility and opposition and was successfully established because of its underlying principles.

Back to Bevan aimed to examine these key themes, assess whether they are still applicable today or need to be re-examined and reformulated to make sense of a rapidly changing world.

The speakers at Back to Bevan were:

Professor Ceri Phillips, Professor of Health Economics and Deputy Head of School, School of Health Sciences at Swansea University

Dr Chris Riley, Dept of Health and Social Services, Welsh Assembly Government

Professor Graham Watt, Norie Miller Professor of General Practice, University of Glasgow

Professor David Hunter, Professor of Health Policy and Management and Head of the Centre for Public Policy and Health, Durham University

Professor Marcus Longley, Director of the Welsh Institute for Health and Social Care and Professor of Applied Health Policy, University of Glamorgan

The event was hosted in south Wales by Dr Chris Jones, Medical Director of NHS Wales and co-Chair of 1000 Lives Plus, and in north Wales by Dr Brian Tehan, Associate Medical Director, Betsi Cadwaladr University Health Board. Professor Sir Mansel Aylward CB, Chair of the Bevan Commission and Public Health Wales, and co-Chair of 1000 Lives Plus, hosted the Q&A session after the presentations.

The work of the Bevan Commission so far

Professor Ceri Phillips and Dr Chris Riley co-presented the first session, laying out the background to Bevan's founding principles and the Bevan Commission. They explained how the Bevan Commission was established to reassure the Welsh Government that the reforms in NHS Wales would create a health service that would be recognisable to Aneurin Bevan.

The Commission set out to identify values that could be enshrined in NHS Wales and underpin all future development in the health service. The principles of the NHS are enduring, but must be applied in new ways to fit current circumstances, and it has to be recognised that circumstances have changed considerably in the past 60 years, and society is still rapidly changing.

A sense of perspective is needed on the idea that healthcare in Wales should be 'world class'. "America says that it is world class at baseball, but no one else plays." 'World class' has been defined as the healthcare that 'best suits the needs of the people of Wales, and is comparable to the best anywhere'.

This definition opens up several key areas for discussion about meeting need. A huge challenge facing NHS Wales is how to best meet the needs of the elderly. There are many boundary / interface issues, between primary care and secondary care, and between clinical care and pharmacies.

An integrated healthcare system joins up the pieces so that patients don't 'fall through the gaps'. But integration is challenging for numerous reasons. Accelerating best practice will remove some financial pressures, because better practice is often cheaper. Minimising harm, waste, and variation will help the NHS to meet need in a more timely and effective way, and also help allay budgetary pressure¹.

The Bevan Commission Principles include the need for shared responsibility for health between the people of Wales and the NHS. But this is a wider issue than just the NHS. The health of an individual is affected by many factors, including opportunity to work and better housing.

All government policies have a 'health impact', and health needs to be a consideration in all policies. For example, if unemployment rises, the health of those affected is likely to be adversely affected through stress and social isolation, and that will lead to additional demand on the NHS. Bevan himself realised that the NHS alone could not solve the country's health problems. As the Minister for Health & Housing, he was fully aware of the links between people's living conditions and their health.

Equally the health sector can help achieve other government objectives. For example the NHS could considerably aid the battle against child poverty and its consequences. The NHS is responsible for 40% of the Welsh Assembly Government. This money should be both spent well on health related objectives, and careful thought given to ensure it also aids other aspects of policy such as economic regeneration as well as reinforcing the efforts of other services such as social services and education.

The public is the best judge of the effectiveness and quality of the NHS. The people of Wales are a great untapped resource in a time of austerity and they need to become active participants as the NHS seeks to improve.

Information is a powerful tool to change minds and behaviour. The decision to move beyond a market-system in NHS Wales means that a new mechanism to drive forward improvement is needed. The Bevan Commission paper 'A Visible Hand' outlines how transparency and public accountability can fill such a role by motivating NHS organisations to improve.

¹ These themes are discussed further in Gray, J, *Accelerating best practice: Minimising waste, harm and variation*, published by 1000 Lives Plus. <http://tinyurl.com/abp-paper>

Exploiting information to the full and using it to drive preferred behaviour within the public sector needs to become routine. A desire for excellence can be stimulated through a policy of transparency. Used well, it is like holding a mirror up to people that will cause them to change when they do not like what they see. In the health field it could allow all the main players - the public, the media, and those working in healthcare - to judge the performance of the NHS, and think what must change and how

Scotland's Strategic Direction

Professor Graham Watt introduced some of his perspectives on the NHS in Scotland. Referring to the principles of the NHS, he noted that Aneurin Bevan avoided the use of statistics, which could be manipulated by both sides in any debate, but instead argued on principles.

He quoted Bevan, who said: "Illness is neither an indulgence for which people have to pay, nor an offence for which they should be penalised, but a misfortune, the cost of which should be shared by the community."

This led Professor Watt to conclude that: "The NHS isn't just a healthcare system. It is an expression of national values, and marks us out from other countries, who may speak the same language, but have different principles."

"The NHS is, and more and more needs to become, a social institution based on mutuality and trust, as an alternative to market competition."²

Professor Watt described the suggestion that we cannot afford principled healthcare as "perverse" in one of the world's richest countries.

"When we remember those who gave their lives in World War II we should also remember and honour the men and women who survived the war and were determined not to go back to the kind of society that existed before. Without them our society would be much poorer.

"The suggestion that we can no longer afford the NHS ... lacks moral authority and is disrespectful to our parents and grandparents whose gift to us, the NHS is."

However, there are key issues facing the NHS, some of which have been created or facilitated by the existence of the NHS. The 'inverse care law' seems to widen the gap between financially privileged and deprived communities, and some of this may be due to the post-war structure of the NHS that has not changed much in the intervening years.

"The inverse care law is still with us. 'The availability of good medical care tends to vary inversely in relation to the need for it in the population served.'³

"Originally it was about market forces, which then, as now, have no track record of delivering for everyone what they provide for a few. But that's not the only meaning of the inverse care law."

² It is worth noting that 'mutuality' in this context refers to a principle, not to 'mutual societies' whose approach to providing healthcare Bevan disagreed with.

³ Tudor-Hart, J. *The Inverse Care Law*, *The Lancet*, Volume 297, Issue 7696, Pages 405 - 412 (27 February 1971). This article can be read for free at <http://www.sochealth.co.uk/history/inversecare.htm>.

Professor Watt introduced Scottish research that showed that the prevalence of health problems rises two and a half to three times from the wealthiest members of society to among the most poor. "But the distribution of general practitioners is flat." He also remarked that in England the situation is worse with fewer GPs working among poorer segments of society.

This can be reversed, but it will need a change in the way resources are distributed. "The inverse care law is not a God-given law. It is a man-made policy. Since the beginning of the NHS access to the frontline has been rationed, in the same way that bread, butter and eggs were in World War II - everyone gets the same."

"That's not a criticism of Bevan who was addressing the problems of his day. Removing the fear of falling ill and not being able to access treatment, or of financial ruin if you did - that was and is a huge social achievement. But it's not enough." More has to be invested in poorer communities; otherwise the NHS itself widens the gap between rich and poor.

Professor Watt's involvement in the Deep End project⁴ that works in the 100 most deprived general practices in Scotland has convinced him of the continuing pernicious effect of the 'inverse care law'.

Key points about encounters between clinicians and patients in Deep End practices include:

- Multiple health problems and social complexity
- Shortage of time for practitioners
- Reduced expectations
- Lower enablement
- Low health literacy
- Practitioner stress
- Weak interfaces, for example, between health and social care

"The inverse care law is not about the difference between good medical care and bad medical care. It is about the difference between what high calibre primary care teams can do in time-poor circumstances, and what they could do with extra time and better support. This matters much more now than it did in Bevan's day."

"In 1948 the NHS had very few effective treatments. Now we have an armamentarium of treatments of proven effectiveness, which when applied to large numbers of people, mostly in primary care, improve population health. The corollary is that if healthcare makes a difference, but is not distributed according to need, the NHS itself widens inequalities in health."

The sheer size of the NHS proves problematic in improving systems, particularly in terms of 'joined-up' work between different areas of healthcare. "As an organisation the NHS lacks contact with many of the local teams in its frontline. This is perhaps the most spectacular example of fragmentation in the NHS, but the problem of fragmentation is widespread."

Professor Watt listed a number of incidences where NHS services are fragmented, including "episodes of care that take place without reference to what has happened previously or what will happen next" and "separate elements of care [that] proceed in parallel with the left hand not knowing what the right hand is doing".

⁴ This project is so-called because the clinicians involved are 'in at the deep end' and 'barely keeping their heads above water'.

He concludes: "primary care is an armada of unconnected small boats going about their business in their different ways". "Of the many components of quality that are frequently discussed, the one most distinguished by its absence is connectedness in the system."

To fully impact 'poorer' communities, the NHS needs people rooted in those communities. It needs small, committed local teams, not poly-clinics, or locums, or clinicians recruited from overseas. The GP remains the main contact between the NHS and the public. Serial contact with the same clinician builds continuity and trust.

The GP acts as "the hub of the health service. But hubs on their own are of limited value". Without regular contact between senior managers and strategists and frontline local teams, NHS services will become fragmented. "We need wheelwrights to link GPs to other services, community care and the voluntary sector. This is the antidote to fragmentation."

"The people who most need continuity, co-ordination, flexibility, long-term relationships and trust, in Tudor-Hart's words: initially face-to-face, eventually side-by-side, are the 15% who account for 50% of the work of the NHS. But by a twist of personal fate, all of us might need such care tomorrow."

Mutuality is widely recognized as a key principle towards achieving this, but often in the NHS "We pass the written and fail the practical." "Mutuality means sharing the responsibility and the power."

England's Increasingly Unrecognisable System

Professor David Hunter began his presentation in uncompromising directness. "Bevan would only just about recognise the NHS," he said. "Free at the point of delivery is the only principle invoked." However, "Bevan's principles were also on the way things are delivered."

"This is a critical point because many of those who ostensibly support the NHS view it principally as a funding mechanism rather than as the deliverer of care services which, they believe, could just as well (or better) be undertaken by a range of for-profit and not-for-profit bodies as well as public ones."

"I would argue that much in Bevan is not just about how we fund healthcare, but in how we organise and manage and deliver it. And in each of those areas I think the system is under mounting pressure and challenge in terms of how we can retain those founding principles."

Professor Hunter noted that the drift away from Bevan's principles has been happening for some time. Change in the late 1990s preceded many of the drastic reforms being introduced in England following the election of a coalition Conservative-Liberal Democrat government in May 2010. "The spectre of Tony Blair hangs over what the coalition do. These reforms take the marketization of the NHS further."

"The evidence base for the market as the solution to the challenges facing the NHS is limited and contested." The case for reform has not been made. The NHS is performing well and better than many healthcare systems in other countries. Public satisfaction is running higher than ever in 2010, a result, says Professor Hunter, of "significant funding and 'terror by target' performance management."

Despite this, the new government has embarked on "the biggest upheaval since the creation of the NHS", which "amount to a move away from an integrated planned

approach to healthcare and to fragmentation and duplication arising from moves to promote choice and competition.”

Professor Hunter issued a plea to stop “redisorganising”, quoting international healthcare improvement expert Don Berwick, who pointed out the debilitating effect of constant reorganisations in 2008.

“...[T]he leaders of the NHS and government have sorted and resorted local, regional and national structures into a continual parade of new aggregates and agencies. Each change made sense, but the parade doesn't make sense. It drains energy and confidence from the workforce....[T]he time has come for stability, on the basis of which, paradoxically, productive change becomes easier and faster for the good, smart, committed people of the NHS.”

Professor Hunter referred to the negative effect of continual systemic change, that only tackle surface issues. “This constant redisorganisation has been a major distraction from addressing the real drivers for change that need to be put in the system.”

“Paradoxically, you need stability in organisations in order to change them effectively. The last thing you do is constantly fiddle around with the structure and the organisational map of the NHS. What is necessary is a real look at what those organisations are doing and how they are operating, not on whether one wants to move from primary care trusts to GP consortia or whatever.”

“Most of what the government seeks to achieve by way of strengthening clinician engagement could have been done within the existing arrangements and without the need for legislation and big bang change none of which was heralded prior to the election.”

The changes in NHS England are being driven by ideology that simply does not have the evidence base to back it up. “The Prime Minister believes that people don't care where healthcare is provided as long as it is high quality. The power of the market is the mantra of change.”

Politicians may think that people want choice, but opinion surveys suggest people prefer reliable local services of a uniform quality. The experience of independent hospitals prior to the NHS resulted in growing inequalities between locations. Indeed, these became intolerable and led in part to the establishment of the NHS. Such inequalities are not in the public interest, and are not what the public want.

“The notion of consumerism in preference to collectivism is a major challenge to those principles that Bevan articulated so clearly about his vision of the NHS being about the gift relationship between the people and government over the provision of healthcare.”

The consumerist or market perspective will change the way the NHS relates to the citizen. “Responsibility is being put on the individual to take charge of his or her health. The transfer of risk from the state to the individual is a large part of what is happening in these reforms. So you get a very different relationship between the state and the citizen than Bevan set out in his vision for the NHS.”

The main reason for this change is that the state will only have a duty to pay for services, not to provide them directly. “[The reforms] will leave the NHS ... publicly funded, but with a plurality of providers, many of whom haven't clearly been identified yet. Many could be large multi-national corporations whose shareholders live abroad and to whom the companies will ultimately be accountable.”

While the government talks about the relationship between the state and the citizen, in terms of the 'Big Society', about which there remains a lack of clarity as to what it entails, it still emphasises consumerism not collectivism. The boundary between 'public' and 'private' is becoming blurry. There is a growing marketization of public policy in a market framework that is 'free', that is, totally unplanned⁵.

"The government talk in soothing terms about the new mutualism, social enterprises and co-ops and warm words like that. But in reality, and for the most part, those aren't the sort of organisations who will be running the health service in future."

"There may be a handful of those in a tokenistic gesture, but the majority of healthcare is more likely to come from well-organised, profitable, commercial companies, many of whom are in this country already, or will come in from other European countries and beyond."

"The fact that the market in healthcare will be open to European Union competition law is significant in regard to an expectation that the provision of healthcare in England will be by for-profit commercial companies."

With GP consortia in charge of around 80% of the NHS budget, there is a drive towards localism. "The NHS is becoming a façade - a brand. Soon there will be no *national* element in the national health service."

However, the proposed role of local government taking charge of public health and overseeing the provision of services at local level in the new structures may well have been something that Bevan would have approved of, as it allows for potential democratic interventions by the public into the provision of services.

However, Professor Hunter identified other dangers with localism and local selection of services between competing providers. Commercial companies may drive down costs, but this could lead to significant variation in quality between providers in different areas, and between social and commercial enterprises. "The government have backtracked on the issue of price competition but there remains a suspicion that it will resurface if only because a true market can only function if there is price competition."

"The move away from national tariffs to an open market... [will lead to] a free market based on price competition not just on quality. All the economists will tell you, even those who are pro-market, to compete on price triggers a race to the bottom in terms of quality being the victim."

Professor Hunter concluded by quoting Aneurin Bevan that the NHS is "a triumphant example of the superiority of collective action and public initiative applied to a segment of society where commercial principles are seen at their worst."⁶

However, "Bevan would be concerned that this reform is not over technical issues, but political issues over which the public should rightly take a view."

"The concentration on competition and markets may prove fatal to the ideals of NHS. The NHS will become a brand - a 'hollowed out' shell organisation. But most worryingly, this is

⁵ Bevan described the unplanned society that results from competition as "profoundly unscientific", adding that capitalist market-led systems are incompatible with principles. "It proceeds upon no hypotheses, because that would imply an order of values." Aneurin Bevan, *In Place of Fear*, Simon & Schuster, 1952, page 50.

⁶ Bevan, *In Place of Fear*, page 89

policy by stealth pursued by a government that has no mandate to reorganise the NHS in the way that has been proposed.”

Wales - a different approach

Professor Marcus Longley stressed the “totemic and real significant link between NHS Wales and Aneurin Bevan.” The Welsh background of the NHS's founder, especially his experiences of socialised healthcare in south Wales, played an important part in the formation of the NHS.

Wales has taken an increasingly different approach to the NHS than England, following devolution. Most of the pledges about healthcare made in the government's 'One Wales' programme have largely been delivered. However, the commitment to 'democratic engagement' remains somewhat problematic, and it highlights an interesting ambiguity and ambivalence about the role of both patients and citizens which is worthy of examination.

This is particularly relevant in relation to the 5th and 10th principles helpfully set out by the Bevan Commission: a service that values people, and patient and public accountability. It is not surprising, perhaps that these principles are particularly challenging. What we mean by valuing people and accountability are probably quite different in this 24/7, hyper-connected, relatively affluent and diverse society, than they were in Bevan's post-war Britain.

NHS Wales faces challenging expectations from the people of Wales, which is made more complicated by different people wanting different things. Expectations have changed dramatically since Bevan's day, and are still changing.

The commitment to place 'patients at the centre' is laudable, but there is confusion over exactly what it means. “Being stuck at the centre of a roundabout as traffic speeds past isn't ideal!”

There are several different ways of engaging patients, ranging from the sorts of 'collectivist' approach with which Wales probably feels most comfortable, to outright 'Patient Power', which emphasises the individual and choice.

An interesting alternative is to think about 'Co-production', a term popularised here by Professor Julian Tudor Hart, and which finds ready acceptance in Scotland. This helpfully avoids the polarisation of 'collective' versus 'individual', and emphasises the need for individual patients and clinicians to work together. It is about partnership and equality of expertise and experience. The clinician's expertise needs to shape the patient's experience, while the patient's experience will ultimately determine the outcome.

'Patient Power' is a difficult concept to define in a way that people generally agree with. “It is hard to find anyone who wants a disempowered patient.” In a non-market setting, quite how patients are meant to behave has not been explored fully. Patients have not been told what to do or what is expected of them. In the absence of quasi-market mechanisms, Professor Longley asked, “What would we want patients to do and how do we give them the tools to do it?”

In the absence of clear answers to these questions, we organisations need to beware of 'Institutional indifference'. NHS Wales' huge local health boards could easily slip into that, since there are few, direct sanctions for those which don't “have a powerful notion that they exist entirely for the benefit of patients.”

Steps need to be taken to guard against unwitting prejudice, ignorance and thoughtlessness. Professor Longley recounted a patient story about a wheelchair-user who needed a disabled parking space when attending a particular hospital department. There was one space near the entrance he used, and so he would be at the hospital at 7.45am to ensure he got that parking space, even though his appointment was not until 10.30am.

“This hospital was not being run by incompetent, nasty, self-serving staff at all. And yet they tolerated this situation every day when they went to work, where the situation was being repeated.”

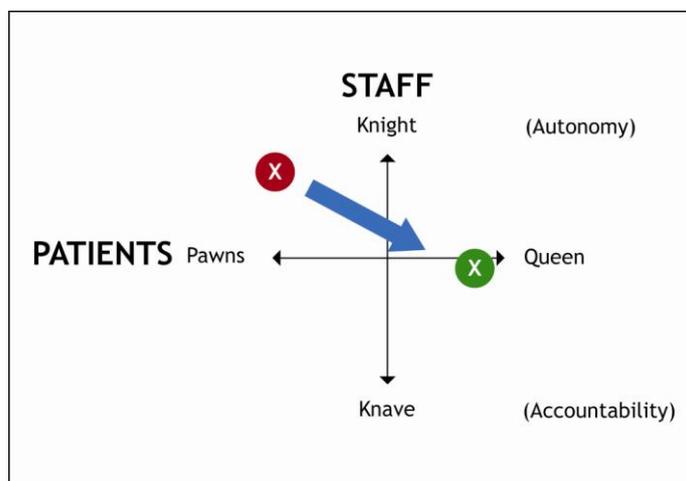
Comparing that lack of care for the user with the kind of customer care offered by commercial organisations, such as supermarkets who provide many priority spaces, Professor Longley commented: “It’s a sad comment on how some services are run that we can’t do better than Tesco.”

“Altruism is an obvious characteristic of most people who work in NHS Wales.” However, “of course, staff have self-interest.” Julian Le Grand, a key advisor to Tony Blair, characterised two types of staff - knights and knaves⁷. “Knights can be left to get on with things, while knaves need someone breathing down their neck.”

Additionally, patients can be regarded as pawns to be moved around to suit clinicians and managers, or they could be the most important piece on the board (the queen).

The NHS may have “relied too much on the knightly qualities of staff and the quiescent attitude of patients.”

As the following diagram shows, becoming ‘patient-centred’ would see a move from a ‘Knight-Pawn’ worldview of autonomous clinicians and powerless patients, towards a ‘Knave-Queen’ view of accountable clinicians who consider the patient the most important person in the care system.



This drive towards less power for clinicians and more power for patients characterised UK (i.e. English) government health policy under Labour. The new Coalition government, while adopting new rhetoric, probably shares much of this world view with its predecessor, although there are worries that the pendulum has swung too far towards treating all public servants, including NHS workers as ‘knaves’.

⁷ Julian Le Grand (2003) ‘Motivation, Agency and Public Policy. Of Knights, Knaves, Pawns and Queens’ Oxford: Oxford University Press

Professor Longley quoted from 'The Big Society', written by the Conservative MP for Hereford and South Herefordshire, Jesse Norman. "Every effort has been made to control people from the centre. Vital but intangible values such as those of [professional] morale, pride and public service have been undermined in favour of incentives designed to tweak behaviour. Trust has been driven out of the system."⁸

Additionally, Norman calls for "... a significant re-shaping of public services to reflect how people actually think and behave..." He advocates "A systematic focus on empowering front-line staff and allowing them to get on with the job."⁹

The growing divergence between Wales and England can also be seen in the Welsh notion that there is 'one public service' that works together towards the same ends. In that vein, suggestions have recently been made for social services to be offered in the 'health board footprint' to allow for further integration.

Looking more broadly at health policy in Wales, and its relation to the Bevan Principles, Professor Longley outlined some 'paradoxes' between the rhetoric and the reality.

Some paradoxes	
What we've said...	What we've done...
<ul style="list-style-type: none">• Patient at the centre• Focus on what matters• Keep at it• Move care out of hospital• ICT is crucial• Information = improvement• Reduce health inequalities	<ul style="list-style-type: none">• Little autonomy, rationing• Multiple priorities• New priorities all the time• Investment unchanged• Spend little• Keep it behind closed doors• Struggle with complexity

We struggle with the notion of transparency. At best the mirror being held up to the health service is "a cloudy mirror". Information about performance is "not shared outside the magic circle". In some areas, such as reducing health inequalities, "there is a long way to go."

Professor Longley, however, outlined 'five clear successes' where the Welsh approach had undoubtedly achieved positive change. They are:

- Mandated joint working: the mental handicap strategy was an early example of this
- Co-production, for example, in dental services. In a generation, the application of fluoride by people, working with their dentists, has dramatically reduced the number of fillings that people have.
- Embracing diversity - in primary care there is acceptance and accommodation of diverse needs and recognition that one size does not fit all.

⁸ Jesse Norman (2010) 'The Big Society. The Anatomy of the New Politics' Buckingham: University of Buckingham Press, p.140

⁹ Ibid, p. 216

- Focus - waiting times have been reduced “because we kept at it until we succeeded”.
- Unity of staff and organisations, for example, through the 1000 Lives Campaign, which demonstrates what can be achieved when professionals and the NHS both really believe in the value of a strategy

“We have learned a difficult lesson. Brilliant analysis, perfect strategy, sound values, well-meaning people do not guarantee unequivocal success. There's more to it than all those things that we are very good at.”

There are five generic success factors that combine to be the missing ingredient:

- Unreasonable ambition - Professor Longley pointed out that aiming to be ‘world class’ is ‘unreasonably ambitious’
- Strategic insight - understanding how to translate vision to reality
- Distributed leadership - being brave enough to let front line staff innovate
- Speaking with one voice - sharing a belief in the key issues, and saying so
- Feedback - must be wanted and acted upon

Bevan's three key principles - universal, comprehensive, free - are still relevant, but in reality the NHS has never delivered on all three, except for short periods of time. There has always been compromise.

There are now eleven principles, and moving forward NHS Wales needs to identify which are the most important. In the end, determining priorities is the job of the politicians - in a slightly different context, Bevan himself argued that ‘the language of priorities is the religion of socialism’¹⁰.

Drawing Conclusions

The principles derived by the Bevan Commission need to influence both what is delivered and the way it is delivered, if they are to retain the spirit of Aneurin Bevan's ideals.

Similarly, those principles need to be continually assessed and adapted for a changing society that is markedly different from the world the NHS was born into. The expectations made of the NHS have hugely altered in the past 60+ years.

The Bevan Commission Principles, as defined in the past few years need to be realistically assessed. Many of them are under threat from the unprecedented economic challenge that the NHS faces at present. In Wales the NHS is afforded significant protection from the politically-motivated reorganisation being rapidly introduced in England.

However, complacency could easily lead to the erosion of the principles underlying the services offered in NHS Wales. Some of the potential threats are outlined below. (*Quotes in this section reiterate points made by the seminar speakers, quoted earlier in the paper.*)

Principle 1 - Universal access, based on need

The idea that everyone is entitled to healthcare, and more specifically, the freedom from worry regarding health issues, has to remain central to what the NHS does.

¹⁰ Said in a speech at the Labour Party Conference, Blackpool 1949

Bevan said: "Illness is neither an indulgence for which people have to pay, nor an offence for which they should be penalised, but a misfortune, the cost of which should be shared by the community."

The reality underlying this, is that either the whole of society pays for treatment, or society suffers the economic impact of large-scale poverty. It is in everyone's self-interest to have the 'safety net' of a healthcare system.

Poverty impacts everybody in society, in terms of high crime leading to damage to personal property and higher taxes to pay for policing, poor shared infrastructure, low levels of wealth creation and enterprise, illness among the workforce, loss of skilled workers, the ever-present threat of uncontained and untreated disease, and so on.

Whether society funds healthcare or not, society pays the price of illness. Adopting Bevan's principle means that society bears fewer costs, while making the morally right decision to alleviate illness and suffering and enable people to live fulfilled lives free from the debilitating effects of disease and the fear it engenders.

Principle 2 - Comprehensiveness, within available resources

The 'available resources' bit is the key element of this principle, given the economic pressure faced by NHS Wales. There are also much higher expectations over what medical science can deliver. The world has significantly changed since the foundation of the NHS.

In order to deliver 'comprehensive' care in future, there must be an emphasis on safeguarding resources, in terms of money, property, workforce skills, and intangible resources such as patient goodwill.

New treatments may be innovative and costly, yet have limited impact, so there will be a need to assess the effectiveness of treatments. All money spent in NHS Wales has an 'opportunity cost' - it cannot be spent elsewhere. So, 'comprehensiveness' may need to include an element of 'best use of resources'.

In England, it seems that under current government plans, the 'national' element of the NHS will disappear in the spirit of 'localism'. Services will vary in comprehensiveness and quality, depending on who offers the services in a given area. There is already variation but this will become much more pronounced if the changes go through. In Wales, offering genuinely comprehensive care will mean the same quality service is offered everywhere.

Principle 3 - Services free at the point of delivery

In a 'paid-for' healthcare system, the people of Wales would be at the mercy of market forces, which "have no track record of delivering for everyone what they provide for a few."

In England, the possible plurality of providers bidding to operate NHS services means that eventually, "the provision of healthcare in England will be by for-profit commercial companies." It would then be a small step to 'paid-for' healthcare.

Services may be delivered free - removing the worry that clinical treatment cannot be afforded - but there needs to be an understanding between NHS Wales and the people of Wales that NHS treatment is not so much 'free' - in fact healthcare is very expensive - but it is paid for in a mutual, communal way.

There needs to be less of an emphasis on 'free' services, and more of an emphasis that 'we support each other' so that the NHS becomes "a social institution based on mutuality and trust, as an alternative to market competition."

Principle 4 - A shared responsibility for health between the people of Wales and the NHS

In England, "Responsibility is being put on the individual to take charge of his or her health. The transfer of risk from the state to the individual is a large part of what is happening in these reforms. So you get a very different relationship between the state and the citizen than Bevan set out in his vision for the NHS."

Can a 'shared responsibility' be developed in Wales that does not see the state abdicate its responsibility towards the individual, but rather, empowers the individual to make positive health choices, with a reassurance that there will be a 'safety net' if needed?

In line with this principle, patients need to be aware of their responsibilities and given the right 'tools' to help inform change. Are patients told what they need to do? This area needs to be more fully explored, particularly if genuine partnership (or 'co-production') is to develop between the NHS and the people it serves.

Principle 5 - A service that values people

The growing commitment within NHS Wales to place 'patients at the centre' means that all NHS organisations "have a powerful notion that they exist entirely for the benefit of patients."

There should be no place within NHS Wales for institutional indifference. NHS organisations need to be self-critical and self-aware, and open to suggestions to improve. Bevan himself said, "Not even the apparently enlightened principle of the 'greatest good for the greatest number' can excuse indifference to individual suffering. There is no test for progress other than its impact on the individual."¹¹

While the clinician's expertise needs to shape the patient's experience, in turn the patient must be listened to, as the experience of patients will show the clinician's true level of expertise.

There is a need to value both sides - staff and patients. The altruism of staff is not always recognised or appreciated. The very real gripes of those working in NHS Wales may well fall on deaf ears. Institutional indifference may well begin with ignoring those working within the institution.

If the concerns of staff aren't listened to - particularly frontline staff members who engage most frequently with patients - then there is little hope of genuine engagement with service users.

Principle 6 - Getting the best from the resources available

An integrated healthcare system joins up the pieces so that patients don't 'fall through the gaps'.

¹¹ *In Place of Fear*, page 178

“As an organisation the NHS lacks contact with many of the local teams in its frontline. This is perhaps the most spectacular example of fragmentation in the NHS, but the problem of fragmentation is widespread.”

To get the best from resources available, there is a need for:

- Systemic stability to allow change for improvement
- The acceptance and accommodation of diverse needs
- Genuine reflection and self-critique
- A focus on cost that is not just about reducing cost
- Partnership with empowered patients leading to co-production

Principle 7 - A need to ensure health is reflected in all policies

Fragmentation extends beyond the healthcare setting to where the frontier between healthcare and social services becomes fuzzy. If social services are offered in the ‘health board footprint’, practical issues regarding integration will begin to fade.

The ‘Health impact’ of all government policies needs to be accounted for as the goal of improving the nation’s health is bigger than the NHS’s ability to achieve it alone. Government interventions in job creation, education, infrastructure investment, food regulation and more, will all carry with them a positive or negative health benefit.

Better integration with all aspects of government policy will give the people of Wales the ‘world-class’ service they demand, with higher service quality, lower cost and greater timeliness.

Principle 8 - Minimising the effects of disadvantage on access and outcome

Health inequalities exist and can only be tackled with proportional investment in the poorer communities. Services need to be weighted to the communities and people most in need. This will reduce health inequalities, which in turn will lift significant burdens of treatment from the NHS.

“Since the beginning of the NHS access to the frontline has been rationed, in the same way that bread, butter and eggs were in World War II - everyone gets the same.” But this may have to change - “if healthcare makes a difference, but is not distributed according to need, the NHS itself widens inequalities in health.”

Principle 9 - A high quality service that maximises patient safety

Unlike England, Wales can avoid the ‘race to the bottom’ triggered by price competition. A planned healthcare system can emphasise quality in a way that market-based systems simply do not. Quality can become a national feature of health services, with none of the variation that comes from using different providers in different areas.

‘Quality’ does not automatically mean ‘expensive’ - and there is a need to move away from the idea that more expensive treatment is better. The pursuit of quality often results in lower costs. Examples of this from the 1000 Lives Campaign and 1000 Lives Plus are in abundance, for example eliminating avoidable pressure ulcers in one health board resulted in cost-savings of over £1.5 million, and better patient outcomes.

Principle 10 - Patient and public accountability

Ensuring the health service is 'patient-centred' is an inherently good thing. However, the expectations of patients need to be tempered with what the NHS can realistically deliver.

If the NHS is to become "a social institution based on mutuality and trust", there needs to be greater openness at all levels. Currently, information about performance is "not shared outside the magic circle".

NHS organisations need to be open to intense scrutiny and be honest about errors and mistakes. A new culture that seeks to measure for improvement, not to apportion blame, has to develop. Politicians in Wales, from all sides, need to support the NHS as it becomes more transparent, and resist the urge to use the NHS to score points. This is 'our' social institution and it is in all our interests to support it as it improves.

Principle 11 - Achieving continuous performance improvement across all dimensions of healthcare

Performance improvement in NSH Wales should also include meeting cost targets as cost is a legitimate measure of quality¹². High costs, or unexpected costs, are often indicative of poorer quality services.

Quality is also dependent on many of the other Bevan Commission principles. For improvement to happen across all healthcare dimensions, there has to be an emphasis on closer working and better links between different healthcare institutions. Fragmentation has to be addressed as a serious barrier to quality.

Improvement cannot occur without a commitment to place patients centrally, review systems and procedures, and seek change on the basis of better outcomes for those being treated.

There has to be transparency within the system, and for those looking in from outside the system, with an emphasis on learning from errors and poor performance. The viewpoints of staff and patients must be sought and valued to identify those areas where quality is absent.

Good planning that encompasses the whole of the system will protect quality against the vagaries of market forces, and can also embed better practices more quickly within different healthcare locations.

Ultimately, the judgement of whether NHS Wales is delivering quality services will depend on whether its services are living up to the principles it espouses. Assessing whether the other Bevan Commission Principles are being adhered to, will be a good starting point for any analysis of whether NHS Wales is achieving continuous performance improvement.

Video highlights from presentations at the 'Back to Bevan' seminar are now available online at <http://tinyurl.com/68nggw3>

¹² Don Berwick makes this point in Gray, J, *Accelerating best practice: Minimising waste, harm and variation*, published by 1000 Lives Plus. <http://tinyurl.com/abp-paper>

About the author



Professor Sir Mansel Aylward CB is the first-ever Chair of Public Health Wales - a new unified NHS Trust responsible for the delivery of public health services at national, local and community level in Wales. He is also Chair of the Bevan Commission and co-Chair of 1000 Lives Plus, the all-Wales NHS improvement programme.

He is the Director of the Centre for Psychosocial and Disability Research at Cardiff University extending knowledge and understanding of the psychosocial, economic and cultural factors that influence health, illness, recovery, rehabilitation and reintegration and a visiting Professor at several universities in Europe and North America.

A qualified physician, he entered the British Civil Service in 1985. From 1996 to 2005 he was Chief Medical Advisor, Medical Director and Chief Scientist at the Department for Work and Pensions, and Chief Medical Adviser and Head of Profession at the Veterans Agency, Ministry of Defence. He was closely involved in developing the UK's successful "Pathways to Work" initiatives and a framework for Vocational Rehabilitation.

He is keenly interested in addressing the health, work and social issues relevant to morbidity, mortality, work, economic inactivity and social exclusion in the South Wales Valleys where he was born and brought up.

Professor Sir Mansel Aylward CB was knighted in the Queen's New Years Honours 2010 for services to health and healthcare.

Are Bevan's principles still applicable in the NHS?

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