Saving the NHS

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I have been actively engaged in health policy for 20 years, chaired the NHS Alliance for 18 years, was President of NHS Clinical Commissioners and am Senior Fellow in Health Policy at HSMC Birmingham. In recent years I have become interested in the non-biomedical way of improving health and care. I am convinced that a sustainable health service requires medicine to reach beyond its narrow conventional boundaries and begin to call on the full range of activities that affect individual health and healthy communities. So I see social prescribing as a key growth point for this kind of integration, and this year I became National Clinical Lead for Social Prescription (NHS England). With the BHMA and the College of Medicine leading this charge, I hope our two organisations will work ever closer and make our messages ever stronger in the mainstream.

As demographic shifts increase demands, even as budget austerity squeezes supply, there are only three ways to save the NHS. Simply improving our efficiency won't work: the NHS is already one of the world's most cost-efficient health services. Therefore, further cuts in provision seem inevitable unless the NHS gets a bigger share of GDP or co-funding is allowed. The third possibility is for the NHS to motivate people to care better for themselves, care for others through volunteering, and increasingly make non-biomedical alternatives to costly health service interventions available.

There are only three ways to save the NHS. All three will demand a radical change in national thinking with all the accompanying pain and challenges to vested interests.

The NHS is caught in what health experts call 'the scissors of doom'. Spiraling costs due to an increasingly elderly population, more patients with long-term disease, more costly interventions and an increasingly demanding patient population. These demands are not being met by a proportional increase in funding. The inevitable result is increasing waiting times, longer A&E waits and a mismatch between what clinicians can offer and what patients are led to expect, which leads to frustration, unhappiness and clinical burnout.

Currently, the NHS is offering only two solutions, neither of which is likely to work because neither have ever worked before. The first is the claim that we can get a quart out of a pint pot by simply improving our efficiency. Undoubtedly there are efficiency savings to be made, whether it be by increasing the number of operating sessions per week per surgeon, or greater use of technology, or by employing an extended staff in primary care, or by stopping scams such as companies charging outrageous prices for common generic drugs. All these savings need to be made and are being made but it is a lie to pretend that improving efficiency is *the* one answer to saving the NHS. The UK NHS is regarded as the most cost-efficient health service in the developed world (Commonwealth Fund Reports this year and last) and if the drive for ever greater efficiency is demoralising clinicians and managers and leading to increasing shortages of both as they choose to leave the NHS, then there will soon come a point when further saving are really counter-productive.

Sustainability and transformation plans (STPs) are supposed to be the NHS's best option for radical service redesign and efficiency savings. But those leading NHS provision are already saying that STP plans are over-ambitious, and their critics say that STPs are in reality nothing more than cost-cutting.

So as the penny drops that we have reached the limits of efficiency savings, we can expect the NHS to lurch towards its second and final solution – slash and burn. Traditionally budgets for improving health and for social care are the first to be cut – as they have been already. Next we can expect the NHS stop doing 'non-life-threatening' procedures such as varicose veins and in vitro fertilisation. Eventually there will be no fat left. Perhaps only when once the knife is scraping on bare bone and trust board members are being asked to pay for their sandwiches at meetings, will the media and patients call foul!

So what are my three solutions for saving what is undoubtedly the best health service in the world? The first and most obvious was Tony Blair's chosen solution. After he was verbally assaulted outside St Thomas' Hospital by a patient berating him over hospital waiting times, he simply put more money into the NHS. Is it really unthinkable that the UK should increase the percentage of GDP spent on the health service to the sort of levels that are already spent in France or Germany? This should surely be the focus of a national debate on the choices and consequences we face but without, hopefully, the sort of pre-election rhetoric that pretends we can reduce taxes and at the same time improve the health service.

The second solution is to explore more opportunities for co-funding. Co-funding is seen by many as the devil incarnate and the end of NHS values. Yet it happens already. There are many examples – from patients paying for prescriptions, to paying for car parking or television sets in hospitals. Co-funding seems to me inevitable. The only question is where it begins and ends. Most agree that it should never be an issue in any life-threatening situation, but what about there being an element of co-payment for the many who could afford it in areas such as non-urgent and non-life-threatening hospital interventions, extended hours GP consultations or travel immunisation?

The third solution – the third way – is my preferred one. It is the most radical of all. It is to change the paradigm that has been constantly reinforced by decades of empty political promises. It is to see the NHS not simply as a service but as a co-operative, where people and communities are assets with responsibilities every bit as much as rights. It is a new paradigm that asks all of us what we can offer as well as what we want. In a nation where 75% of us volunteer at least once a year, rather than commercialise and ramp up costs and demand as we are doing, we should now capitalise on the vast reserves of altruism and goodwill available.

Having explained 'the new story', government should support its translation at local level allowing the Social Care Act to trump competition law, wherever local health service development is fuelled by voluntary effort or where it has wider implications in improving local health and wellbeing. To signal this changed paradigm, the government should introduce a system of litigation and redress more in keeping with a health service that is free at the point of delivery, rather than one that has been fitted to the needs of big business and the competitive market place. The NHS Litigation Authority has estimated the money needed to settle all medical negligence claims is £25–£30 billion – almost a third of the £115 billion NHS annual budget!

As an example of a new model for bridging health and social care, another symbol of this changed paradigm is the very rapid development of social prescription in the past year. It aims to help motivate people to care better for themselves, care for others and make non-biomedical alternatives to costly health service interventions available. As social prescribers and their patients discover the gaps in the system and find ways of filling them through volunteer, voluntary and other organisations, social prescription will begin to support the communal fabric of health and wellbeing. In subtle ways it is helping general practices to make better use of their registered list to reframe themselves as hubs of local health development. By supporting the development of health-creating communities, social prescribing projects will begin to reduce demands on the NHS and its precious resources.

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There are enormous reservoirs of goodwill to be tapped. People like to help. In my village surgery, patients frequently insist on buying their own paracetamol and in the waiting room will often suggest that a patient who is more ill should go in before them. If we are to make the most of people's wish to volunteer and serve others then we will have to overcome the ever-widening gulf that has opened up between 'service-users' and 'professionals'. In parallel the NHS has become a profoundly risk-averse culture, where lawyers and sometimes clinicians have embedded distrust and demarcation as the system's basic assumptions. The consequent over-medicalisation and professional protectionism has contributed greatly to making the NHS unsustainable.

Some will say all this is unrealistic idealism. There is no shortage of examples of individuals – high and low – who will use foul means or fair to get what they want. But if greed is good, and the gap between rich and poor continues to widen, our sense of belonging to one society will be endangered. Then, if our sense of inter-dependence breaks down, the NHS will not survive. It was founded on, and must continue to be grounded in, solidarity and collective goodwill. It is now up to courageous politicians, committed clinicians and the people themselves to speak out about the choices we face and for us all to demand better of each other.

The 'third way' I have described will require us to re-establish the values and vision of the NHS as one of the 20th century's most wonderful social inventions. This won't happen from the top down: morale and purpose have to be restored at every level. In practical terms it is the only way the NHS can be saved. All the other solutions – increased investment, increased efficiency, cutting out the unnecessary and co-payment – are first aid. They may all have a role but they are will not address the core issue of whether, as a people, we believe in society as a force for good, where the rule is not 'every man for himself'. The meaning of the NHS is inextricably bound up with our choices about what kind of society we want to live in.