Shaping the NHS for the 1990s

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THE dominant theme in the health policy of Western governments in the last decade has been costs – or, to be more precise, finding ways to control public expenditures on health care. In a sense, this has been a negative period. To call it negative is not to deny the importance of expenditure control, but to maintain that it is now time to redress the balance in preparing for the 1990s and to think about ends as well as means.

THE CONTEXT

1 *Demography*

For much of this century, developed countries have been in a long-term process of demographic change. Sharp falls in the birthrate and in infant mortality have gradually resulted in a quite different population profile. It is not so much that the maximum lifespan has changed (though this could happen) as that many more people survive to reach it, as described in last year's Gloucester Lecture by Professor Tom Arie. So far as the UK is concerned, this process will work its way through to its logical conclusion between now and the year 2025, with a large increase in the proportion of the population over 75 and a doubling of the proportion over 85 (Table 1). Since needs rise very steeply with age, the implications for health and social services are obvious. Moreover, only a small proportion, even of the 'old old', are in institutional care. Most preserve substantial independence, living alone or with a spouse, a relative or a friend. That, no doubt, is the pattern most older people prefer, but we cannot too lightly assume its continuance without a strong, flexible network of support from a wide range of social and health services. How imaginatively and how well we meet the heterogeneous needs of older people is a crucial question for the 1990s.

The process of demographic change also means a fall in the 1990s in the numbers entering the workforce. Nationally, we are waking up to this so far as nurse recruitment is concerned, but our answers do not yet sound totally convincing. Health services are people-intensive and bound to remain so. We

Table 1 Demographic context: dependent population per 100 population of working age: by age

United Kingdom	*Dependent population aged*				
	0–15	*65/60–74**	*75–84*	*85+*	*All ages*
1971	43.8	19.9	6.6	1.5	71.8
1981	37.1	20.0	7.9	1.8	66.8
1986	33.5	19.0	8.5	2.0	63.1
Projections					
1991	33.2	18.5	8.9	2.5	63.1
2001	35.8	17.5	9.1	3.3	65.7
2025	34.1	23.3	11.3	3.9	72.6

* 60–74 for women; 65–74 for men
Source: Social Trends 1988/Office of Population Censuses and Surveys.

depend on a wide range of skills, often in unglamorous jobs that are not well paid. If we were ever entitled to take recruitment, retention, motivation and leadership for granted, we would be most unwise to do so in the NHS in the coming decade.

Two other demographic factors are worth remark. First, Britain has become a multi-ethnic community, calling for new sensitivities and bringing a new richness to society, if we have the sense to recognise this. Ethnic minorities currently include 2.5 to 3 million in Great Britain, or about 5 per cent. This percentage will rise because our ethnic minorities are still much younger than the population as a whole. Also, of course, the ethnic mix is very unevenly spread geographically and in terms of income. In inner city areas in particular, the NHS (like any other major public service) will fail in a key duty if it fails black people in its internal policies or in its response to their needs.

Finally, on the demographic front, it seems inevitable for the next decade that there will be continuing population movement from the north of the country to the south east, and that regional differences in employment, earnings and house prices will continue to increase. What should a *National* Health Service mean in this context? By definition it implies an attempt

to deal justly with the whole population, not discriminating on grounds of geography, wealth or colour.

2 *Social and environmental stress*

Demographic change is reasonably easy to quantify and even to predict. The interplay of individuals, communities and the environment is far harder to describe with any precision, but I am certain that it is becoming an increasingly important influence on health. At one level, human behaviour is, we know, a major determinant of the prevalence of disease. AIDS is the most recent tragic reminder, and is unlikely to be the last, where part of our response needs to be a massive change in human behaviour. Changes in lifestyle do not happen easily or painlessly, and they seldom guarantee a gain in health to a particular individual. They are, nevertheless, crucial determinants of the overall health of communities.

The interplay of collective human behaviour and the environment was obvious in Victorian cities. I believe that it will become an increasingly vital (in the original Latin meaning of 'basic to life') factor in our future. 'Civilised man has marched across the face of the earth and left a desert in his footprints.'[1] Locally, nationally and internationally we can no longer take the recovery of the environment for granted. The risks of catastrophe are infinitely higher than a century ago. Nuclear war, nuclear accident, severe air and water pollution, are among the examples where health is at risk. Our future survival depends less on man's proven technical inventiveness and adaptability than on our less proven collective wisdom and restraint. We shall see. Dr Johnson remarked of a man's decision to marry again, after an unhappy first marriage, that it was a triumph of hope over experience. Anyone prepared to bet on such a fundamental change in human behaviour with regard to the environment will have to have a similar degree of optimism. The next ten years may indicate a shift. It will need to.

3 *Medical developments*

On the other hand, there is every indication of dramatic further

gains in biology, medical science and medical techniques. The next decade may be among the most exciting in human history in these fields, parallel to physics in the early part of this century. Genetics is the obvious current example. Further off are advances in our understanding of the mechanisms of cancer and of AIDS, the processes of ageing, and of mental illness.

This will also be a period of rapid technological innovation, as well as step-changes in medical science. Surgery is being transformed by less invasive techniques (lasers, the lithotripter, fibreoptics). Radiology and related diagnostic fields (CAT scanning, magnetic resonance imaging (MRI), positron emission tomography) are also undergoing radical change. Laboratory diagnostics are moving in the direction of reliable, relatively cheap methods, usable by GPs and (in some instances) by patients. Pharmacological innovation still flourishes. Monoclonal antibodies seem to offer a potentially powerful instrument for cancer treatment, much more accurate than conventional radiotherapy, surgery and chemotherapy.

Not all these advances will occur in the next decade, nor will they come smoothly and predictably. But some will come. The decade, therefore, seems certain to be one of great excitement and turbulent change in medicine, with a need to react selectively to new opportunities – selectively because of the ethical issues raised and because of resource constraints. Each major therapeutic innovation will call for careful assessment of its appropriateness and its value. Whether it will receive such assessment is, of course, another matter.

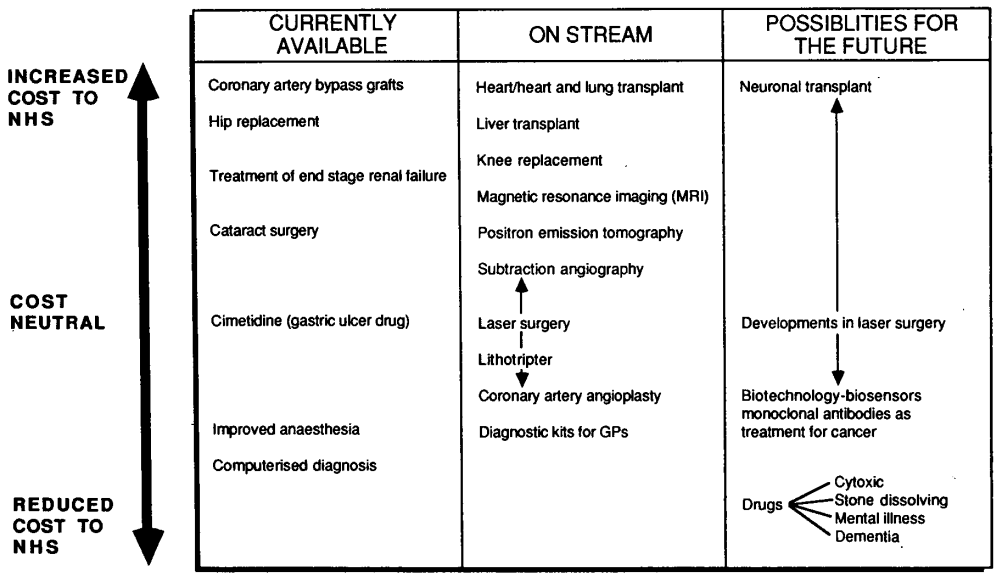
4 *Public expenditure constraints*

Whatever government is in power in Britain in the 1990s, the NHS is not going to have enough money to do everything that we would like. Compared with other countries, our total expenditure of about £450 per head is relatively low. It is also a modest figure when you add up the cost of an average of (say) four visits to a GP each year, plus public health services, plus even a modest call on hospital services. Already there are, as we know only too well, ways in which the NHS falls short

of a decent service – in waiting times for some forms of elective surgery, in standards of care for such vulnerable groups as people with long-term mental illness or dementia, and in fabric and equipment. The demographic changes that I have outlined will increase the demands on the Service. Medical developments will, on the whole, add to the costs rather than reduce them (Figure 1), widening the gaps between desirable levels of provision and what the NHS actually offers.

Neither governments nor electorates like taxation, however, and with a ratio in Britain of government expenditure to GDP not far below 50 per cent, there is substantial resistance to further increases in tax levels. Within public spending, health is the third largest programme, narrowly behind education and science and far behind social security. Any large switching of public expenditure into the NHS would probably require a sharp fall in unemployment (and hence lower social security spending) or a reduction of the defence budget.

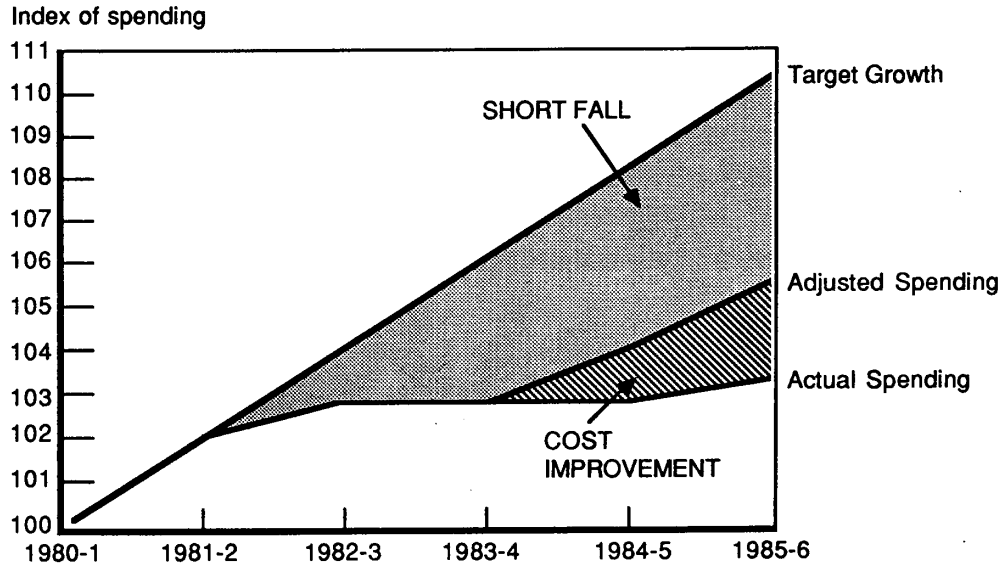
Figure 1 Context of fast moving medical technology



Source: House of Commons, session 1987–88, Social Services Committee, First Report. *Resourcing the National Health Service: Short Term Issues*, vol II, Minutes of Evidence (20 January–17 February 1988). London, HMSO, 24 February 1988, p 34.

This government's preference is to find improvements in health care by internal efficiency savings (Figure 2) and by increased private sector contributions. As John Moore used to point out, when he was Secretary of State for Social Services, a principal difference between our health care spending and most other Western countries lies not simply in our lower overall total but also in a greater relative dependence on public finance (Table 2). This is a fair point, although the make-up of the public and private contributions varies so much in different countries that the crude difference does not by itself prove anything. Private sector contributions may, in different countries, comprise the exclusion of certain services from public payment, or the ineligibility of high income earners (the Netherlands or West Germany) or the imposition of charges for most services (France). None of these is the same as our private sector, which is in competition with the public sector in a different sense.

Figure 2 Hospital and community health care: trends in current spending, targets and shortfall (£m at 1985–86 prices)



Source: House of Commons, Social Services Committee. *Public Expenditure on the Social Services*, vol I, London, HMSO, 2 July 1986.

Table 2 Public and total health expenditures, 1984* (per cent)

Country	*PH/TH*	*TH/GDP*
Australia	84.5	7.8
Austria	60.9	7.2
Belgium	91.6	6.2
Canada	74.4	8.4
Denmark	83.4	6.3
Finland	78.8	6.6
France	71.2	9.1
Germany	78.2	8.1
Greece	79.3	4.6
Iceland	82.7	7.9
Ireland	86.9	8.0
Italy	84.1	7.2
Japan	72.1	6.6
Luxembourg	–	–
Netherlands	78.3	8.6
New Zealand	78.4	5.6
Norway	88.8	6.3
Portugal	71.1	5.5
Spain	72.3	5.8
Sweden	91.4	9.4
Switzerland	–	–
United Kingdom	88.9	5.9
United States	41.4	10.7
Mean†	78.7	7.5
High/Low†	2.2	2.3
Standard deviation†	12.2	1.5
Mean – big seven	72.9	8.0

Notes: PH = Public Health Expenditure; TH = Total Health Expenditure; GDP = Gross Domestic Product
*Figures for 1984 are preliminary estimates.
†Excludes Luxembourg, New Zealand, Portugal, Spain and Switzerland.
Source: *Measuring Health Care 1960–1983*. Paris, OECD, 1985.

What is clear, however, is that any British government, of whatever political colour, is going to have difficulty funding the NHS at an adequate level. This reflects a natural paradox. The NHS is a collective venture of supreme importance, used by

almost everyone, but used differentially. The main beneficiaries (at least if you use spending as a proxy for benefit) are the sick and handicapped. When the individual who needs help is someone we know and love, we want the best care, almost regardless of cost. Collectively, however, we decide upon a level of spending which forces hard choices: what many people get, falls short of optimal care. The more powerful and wide-ranging medicine becomes, the larger the gap.

Thus, the public expenditure background for the NHS in the 1990s is going to be difficult, if not downright hostile.

HOW GOOD IS THE NHS?

The short answer is a great deal better than its detractors imply, but not as good as its founders hoped.

The longer answer would require a series of lectures, if not research studies. Meanwhile, each of you has your own impressions, which you can compare with my attempt (see below) to draw up a summary of strengths and weaknesses relative to the performance of other countries. There is much to be proud of: nowhere in the world is there a better service for the price. But the NHS is not the best in the world. It is less responsive to consumers than most Western systems. It does not encourage or reward high performance by providers.

Strengths and Weaknesses of the NHS

+	−
Cost effective/economical	Lack of consumer emphasis
Moderately equitable	Lack of provider incentives
Comprehensive system of primary medical care	Neglect of capital and maintenance
Good basic professional standards	Some quite severe rationing (for example, waiting time)
Population emphasis (for example, district structure)	Weak on health promotion

Many of its buildings are neglected and much of its equipment outdated. Visitors from Scandinavia and North America are politely appalled at the state of the fabric and the facilities that we accept as adequate. We fall short of decent, affordable standards in waiting times and in standards of service, especially for such vulnerable groups as the elderly and the handicapped. We have done far less well in health promotion and cross-sectoral health policy than the Netherlands, Sweden or Canada.

In summary, in Consumer Association terms, the NHS is a bargain, but one that is beginning to look more like Woolworths than Marks and Spencer.

LIKELY THEMES FROM MRS THATCHER'S REVIEW

The Prime Minister's Review was prompted by public perception of a funding crisis in the NHS, despite the government's contention that it had done all that could legitimately be expected in terms of increasing public spending on the Service. The opposition seized upon the government's embarrassment in the autumn of 1987 (under attack from the presidents of the three leading royal colleges, among others) to force the government onto the defensive. The establishment of the Review was, I believe, an honest attempt to assess whether the funding problem is genuine, and to decide what to do about it. Why the process should be as secretive as it has been, with even the membership of the Review supposedly secret, is a mystery. Nevertheless it would be a great mistake to underestimate the Prime Minister's determination to nail the problem.

The resulting white paper is now expected in January 1989. Publishing guesses about its contents is obviously unwise, not least because there is still time for substantial further changes. However, for the purpose of looking ahead to the NHS in the 1990s, I need to take a view about what will come out of the Review. The list opposite summarises my present assumptions.

Closer integration of medical staff will involve a big expansion of the resource management initiative, by which in half a dozen NHS districts medical divisions have been given a substantial degree of budget responsibility. The danger is that the letter

of the initiative will be pushed rather than the spirit, with an overemphasis on information systems rather than leadership. The initiative is fundamentally a good one, which we must not allow to fail. The responsible use of health care resources is impossible without the understanding and involvement of, among others, the physicians.

Closer integration may also mean some moves to change medical contracts of employment, which the medical profession collectively is likely to view as punitive, such as the ending of career appointments, appraisals of personal performance, and a restructuring of the merit award system. In practice none of these would be particularly sinister. Equally they are signs of a change in attitude. Clinical autonomy – the discretion to treat patients as one thinks best – is going to have to be earned. Effective medical audit is an essential safeguard here, and one that the profession ought to put in place very rapidly.

The concept behind *provider or internal markets* is to promote competition and so to change incentives that people are more directly rewarded for the service that they give. The idea seems a good one. Quite how to make it work in the context of the NHS is more difficult and is probably taking considerable attention in the latter stages of the Review. One line of thinking is to go some way towards separating financing from provision, perhaps at the regional level. The regional health authority (initially in one or more pilot developments) would reduce its provision functions and concentrate on buying services from a wide range of public and private organisations. Another proposal, compatible with this, would be to encourage a number of NHS hospitals to become self-governing, independent of

Likely themes from the Prime Minister's Review

- Closer integration of medical staff
- Provider or internal markets
- Increased consumer choice
- Community care?

their health authority, earning their budget from anyone willing to pay for their services. Basic to proposals such as these is a financing change, at least for the institutions that opt out and probably for others, away from global budgets at the local level and towards some form of payment related to work done. This would attempt to end the current frustrations under which individuals, departments and institutions are prevented from undertaking work because the money is not there.

The trouble with a departure from global budgets is, of course, that it undermines the key financial control on which the NHS is based: that there is a fixed amount of money available from which all services for a given population must be financed. Not only is this an effective control, it also forces hard choices. Quite how best to reconcile the two ideas is unclear. One could, for example, leave the RHAs with fixed budgets from which to purchase all services, encouraging them to use at least part of their allocations to negotiate flexible contracts.

The third theme emerging from the Prime Minister's review is *increased consumer choice.* The reasons are obvious enough, but once again is not so easy to see how. Increased provider competition may be one way. Equally, however, this may reduce the scope for choice in some respects – for example by eliminating weaker institutions – while increasing it in others.

One obvious step is to make it much easier for people to change their GP, although there will be many areas where that freedom is more apparent than real because of a lack of alternatives. The Secretary of State has already indicated (at the Conservative Party Conference) that he will preserve, or even enhance, the GP's freedom to refer patients across administrative boundaries. Rumour has it that the Review is keen to re-examine the idea of budgets controlled by GPs, including payment from their budgets for the hospital patients that they refer. While there are some real grounds for interest in this idea, I doubt its current practicality and even more strongly doubt whether it would enhance consumer choice.

Consumer information is a lever that might prove powerful. At one of the King's Fund consensus conferences, for example,

we showed reasons to question radical mastectomies for breast cancer: the indications since that conference are that many women have absorbed that message, and that their opinion will in turn bring a change in clinical practice.

My final theme from the Prime Minister's Review is *community care*?, with a question mark because it is not clear how the Griffiths report on this topic[2] will influence the Review. Sir Roy Griffiths concluded that health and social care needed to be coordinated in the interests of individual clients and that this would be best done under the aegis of local authorities. That last conclusion – a transfer to local authorities – is sticking in the government's throat and the bone seems likely to remain stuck. On the other hand, something needs to be done to promote and develop community care, as David Mellor, Minister for Health, is keen to emphasise. In default of a wholesale transfer to local government some people are keen to promote the idea of new primary care authorities combining family practitioner services with social services. Structural change on that scale seems to me unlikely against the background of disenchantment with organisational solutions to the difficulties of the NHS. We shall see.

Overall, a package of changes of the kind that I have outlined as emerging from the Prime Minister's Review does not seem to me particularly alarming or sinister. It might in time bring marked changes to the NHS as we have known it, but not necessarily changes for the worse. The question is whether we can seize the opportunities for greater enterprise and combine them with the basic virtues of the NHS – its economy, its attempts to give priority to those in greatest need, and its no-nonsense pursuit of high professional standards.

TOWARDS A STRATEGY

Forecasting the future is an intellectual self-indulgence unless we use that as a background to thinking about a strategic response. Of course my forecasts will be wrong in many details, but they should be close enough to give us all an idea of the texture of the environment for the NHS in the 1990s – the

exciting new challenges, the continuing political uncertainty and the funding constraints.

How best to shape the NHS response is where I want now to turn your thinking, and will do so by highlighting five lines of development that I believe can prove fruitful. Whether I persuade you is less important than whether I manage to stimulate your own generation of viable ideas.

1 *Changing the role of the hospital*

For some time it has been fashionable to talk in the UK about changing the balance of care. I do not want to climb on that particular bandwagon, but to make three points. The most important is that in almost every branch of health care, hospital work needs to inform, and be informed by, what goes on far outside the hospital walls. The starkest instances occur in the poorest parts of the world. Bryant for example in his classic book, *Health and the Developing World*, describes an excellent programme for the hospital care of premature infants in Cali, Columbia, with survival rates comparable to those in North America. Consider the impact of learning that 70 per cent of infants discharged from the premature nursery were dead within three months. 'Such findings', writes Bryant, 'stir an institution to action and give direction to that action'.[3]

Examples in this country would be less stark but the basic message is still the same. A systematic follow-up of survival after intensive treatment for advanced cancer would probably raise some disconcerting questions, not only about cost effectiveness but about humanity. What goes on in any hospital needs to be closely related to the epidemiology of the population that it serves and to what happens to its patients before they are admitted and after they are discharged. Despite the general strength of primary medical services in the UK, the links between specialist knowledge and influences upon the population's health are nothing like strong enough.

My second point is that hospitals are inherently expensive and will become more so, because they are personnel intensive and provide the main base for frontier technologies. We have

to become more selective in how we use them, if only because they are going to be more difficult to staff, most obviously in nursing. Finally, as we have also discussed in the context of the 1990s, diagnostic and information technology is likely to make greater decentralisation feasible.

Historical parallels are never complete, but I am inclined to think we have passed the highwater mark of the hospital in a rather similar way to the rise and decline of the castle in the history of warfare. Hospitals will certainly have an enduring place, but less as complete within themselves – the set-piece siege as it were – and more as an integral part of much more flexible models of health care promotion and delivery.

2 *More effective promotion*

This is another fashionable bandwagon, in rhetoric if not in reality. We cannot safely ignore the logic of what the Canadians call the health field concept: that a nation's health is influenced by lifestyle, the environment and human biology, as well as by the activities of health care organisations, conventionally defined. Again that message is starker in much poorer countries where standards of health can only be transformed by approaches that go beyond the curative – into oral rehydration, for example, clean water and basic child health. In a more sophisticated sense, however, the message is equally relevant to us. Changing smoking and drinking habits; stopping drivers from drinking; reducing accidents in the home, particularly among elderly people and among children in large families.

Despite the rather frosty response given to our own recent publication *The Nation's Health*[4], one does not have to be a natural nanny to recognise the potential impact on loss of life and damage to health that can come from health promotion. Moreover, *pace* Mrs Currie, knitting scarves and woolly socks is not all there is to it. Individuals do indeed have responsibility for their own health, but not sole responsibility. Locally the health authorities and local government and, nationally, central government, can and should tackle some of the key influences, such as drinking and driving, accident reduction, and some

aspects of food policy and environmental safety. At the moment we are substantially behind the best international practice in health promotion, both at the individual and the societal level. We have much to learn from other countries in this field.

3 *Greater clarity about the production function*

What economists mean by the production function is the process of turning inputs into outputs. A curiosity of health care is that these processes are not well documented. While we know a hospital's costs in the aggregate, and something about its intermediate outputs – operations performed, numbers of discharges, days of care given, and so on – this information is not in a form that enables us to track the relationships between specific needs, the costs of intervention, and the results obtained. To put it bluntly, we cannot adequately describe what the community is buying for its money.

Part of the problem lies in a lack of output indicators. In her Gloucester Lecture two years ago, Mrs Körner spoke briefly about quality adjusted life years (QALYs).[5] That is a noble attempt to provide a common currency for describing health outcomes. Imperfect as it is, it is already good enough to raise some searching questions about the way resources are allocated between such major programmes as, say, coronary artery bypass, organ transplants and hip replacements. QALYs will become an increasingly useful strategic tool, helping to illuminate major investment choices. It is likely in my view to remain inappropriate at the operational and clinical levels, in choosing between therapies for a given condition and in triage decisions between patients. There is therefore a need for a far wider range of more specific, less grandiose measures, of health result.

Costing work done is relatively elementary (in principle if not always in practice), once we have defined activities in a form that relates them to needs at one end of the production process and to outcomes at the other. Diagnosis related groups (DRGs) could do this, if (it is a big if) joined to measures of outcome. The difference between this approach and standard

forms of departmental budgeting is worth emphasising. For purposes of clarifying the production function we have to look at disease entities like cancer of the cervix and relate costs to patterns of prevention and intervention, and to convincing evidence about results. A department budget may be useful for control purposes. It is generally quite inadequate as a way of examining value for money.

4 *More intelligent choices about resource use*

This follows naturally from the previous heading and echoes the theme of Edith Körner's Gloucester Lecture to which I have referred already. Health interventions are immensely varied in their impact and cost. Consciously or unconsciously we choose among them in allocating limited NHS budgets. In general, we do not do the job well enough, partly for lack of information about the production function and also because of inertia of various kinds. Allocations based on last year, with marginal adjustments, are less threatening to established interests than are more fundamental attempts to alter existing patterns of distribution. Yet, against a background of potentially rapid medical advance and of substantial demographic shift, we have to be able to free resources relatively quickly from lower priority uses. Perhaps this happens by natural evolution in a free market, although such a market also creates inequities and efficiencies of a kind that we might not want to accept in the public sector. At all events, substantial resource switches do not happen in a large public system like the NHS without intelligent choice and determined action at the district and regional levels.

Variations in resource use are now well documented, not only in Britain but between countries and within countries. Within the UK, referral rates from GPs vary from 1 to 24 per 100 consultations. Surgical rates vary as much as twofold within England and Wales, fivefold among Canadian provinces and sevenfold internationally.[6] Epidemiological variations do not begin to justify differences on this scale. It is not merely a question of doubtful value but of unethical practice. In such a

pattern of contrasting practice styles, not everyone can be equally right. Nor in many cases do we actually know who achieves the best results, so there is a strong professional duty to carry out searching studies of clinical practice and (I suggest) to develop guidelines based on the results. The guidelines should not be rigid, but the outlyers should be expected to justify their practice. If that involves some whittling at the edges of clinical autonomy, it seems to me intolerable to continue a situation in which the main explanations for marked variations in clinical practice lie in inherited inequalities of resource distribution. It also seems to be the case that variations are most marked for procedures where there is least consensus about the indications for them – not a surprising conclusion, but one that again points firmly to the need for rigorous work on outcomes.

5 *More powerful consumer/community voices*

I find this the most difficult of my headings. Not from any doubts about its importance but because I am not at all sure how to bring it about. The Prime Minister's Review may be having similar problems.

The reasons for its importance – endorsed weightily by the World Health Organization – are that health and health care are fundamentally unlike motorcycle maintenance. They almost always depend on the subject as well as the expert. Second, medical choices often raise ethical questions about what *ought* to be done, especially as the opportunities expand to intervene at the beginning and end of life, to choose who will live and when people will die. These are fundamentally choices in which the professional should be the agent, not the principal. Finally, in the allocation of scarce resources, professionals and managers are once again agents. Their insights are illuminating, but in the end the choices should lie in some sense with society.

Health care managers often feel that their health authorities cannot or will not face up to what Mrs Körner called critical choices. That has to be too defeatist a view. I can only suggest that we must work away at it, with a better presentation of

information – designed to illuminate choices, not preempt them – clearer processes of choice, and appropriate organisational and individual development.

There is also something to be learned from locality planning – listening carefully to what local communities actually want, and not assuming that they cannot understand arguments about resource constraints, minimum scale and the quality of service.

Community health councils have an obvious part to play in voicing local concerns and giving views about potential choices. For some of the most vulnerable groups in society – and indeed for others – the advocacy movement can make an important contribution.

As Ken Jarrold, Gloucester's own District General Manager, has pointed out, a National Health Service depends upon an implicit or explicit contract between the public and the providers. If the public voice is weak, then we must strengthen it, if necessary by a serious investment in community development. The parties to any contract need some greater degree of equality than currently exists between the public and the NHS.

* * *

Thank you for your patience in accompanying me on this reflective tour of where the NHS is coming from, the world it is likely to face in the 1990s, and some ways in which we could strengthen it. In conclusion, I want to say a brief word about morale.

Every service organisation depends first and foremost on its staff. The difference between indifferent and excellent performance lies in their quality, their aspirations, their collective achievement. That is a message we forget at our peril in the NHS. There is nothing wrong with the calibre of people we recruit – indeed in medicine, nursing and many other health care occupations, the quality of entrants is outstanding. Teamwork is often good, but more by chance than because we build and maintain it consciously. Through organisational changes

we have all too often allowed institutional tradition and institutional identity to fade, whereas they can provide immensely important touchstones for people's sense of larger purpose. Some district health authorities (of which Gloucester is one) are developing their own distinctive style – 'the way we do things around here'. Regions also can help. At the national level, there is a crucial contribution, all too often not made by ministers and senior civil servants. 'Where there is no vision, the people perish.'[7] So long as the NHS has no national leadership outside central government, staff and the public will depend on ministers for their sense that the NHS and those who work in it are valued, and that it will perform. Enoch Powell remarked long ago on the chorus of disparagement arising from all parts of the NHS. While no one change will alter that, it is an essential message to the Prime Minister, to Kenneth Clarke and to their successors, that under current arrangements the personal leadership of a million people lies ultimately with the Secretary of State. When he speaks, he does so not only as a member of the Cabinet, but as the single individual to whom the whole organisation of the NHS and those it serves listen as its head.

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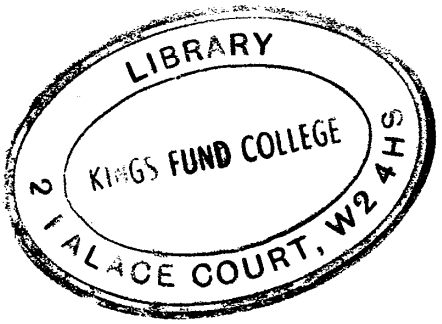

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