Towards an asset-based NHS

The missing element of NHS reform

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On 3 February 2004, the Secretary of State for Health John Reid announced a consultation on public health. It was an important step forward, because public health is well-known to have been the Cinderella of the National Health Service (NHS) for the past generation. This report is published before the details of the consultation have been revealed, but it is intended as a contribution to a growing debate.

The announcement was made to NHS chief executives and the coming debate is couched partly as a way of tackling the issue of chronic health problems, and partly as a question of personal responsibility for personal health.

We support the idea of a consultation, but this report questions the conventional premise under which the public health debate has been developing — questioning the role that retailers, schools and business might have, but ignoring the critical assets that the NHS already possesses: its patients and their neighbours, and its frontline staff.

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Introduction

On 3 February, the Secretary of State for Health John Reid announced a consultation on public health. It was an important step forward, because public health is well-known to have been the Cinderella of the National Health Service for the past generation. This report is published before the details of the consultation have been revealed, but it is intended as a contribution to a growing debate.

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The bulk of John Reid's speech also concerned the issue of choice, and this report will also argue that although patients' choice is important in the NHS, raising it to a central plank of health policy may be in direct conflict with policies that would effectively and sustainably increase participation in health by patients and their neighbours.

Speaking on the *Today* programme during the summer, the spokesperson for the Government's health rationing agency, the National Institute for Clinical Excellence (NICE), described their forthcoming NHS fertility treatment as "the product". It was a reminder, however unnecessary, that the prevailing model shared by government officials for the future of the NHS is as a business, delivering products to consumers in the least expensive way practical.

This is not so much evidence of private involvement in the health service — doctor's surgeries have been privately owned and managed since the start of the NHS. But it is evidence of a mind-set: that the prevailing understanding of the NHS is one where patients are consumers, where the NHS is a system for delivering customer satisfaction, and where health interventions are "products".

There is no consistency about this. The vital idea of patient involvement and the idea that local stakeholders should be involved in the running of local health services — the original idea behind Foundation Trusts — are somehow in the same current policy mixture, while policy-makers wonder why they are not delivering the intended outcomes.

Most of all, with the Health Secretary presiding over a funding bonanza for the NHS — the biggest ever injection of cash into the system, with £68.7

billion promised in 2003/4, an increase of nearly 40 per cent on the 2000 budget, mostly on staff — they are wondering why these funds seem to be failing to have the kind of impact that make reform an obvious success.

One major reason for this intractability is that the consumer model of the NHS — the raising of 'choice' about long–term relationships between patients, professionals and the community — is in some ways in conflict with other modernising ideas, such as those behind mutuality and public involvement. The consumer–based approach to health is one reason why the Chancellor's injection of cash is not having a major impact, but it is also why patient involvement seems so intractable — failing to keep more than a bare minority involved beyond their first flush of enthusiasm.

The key contradiction is that no publicly–funded health service can ever provide total choice. When demands on the NHS seem infinite, infinite choice is simply an impossibility. It also implies giant centralised systems that are responsible for much of the sclerosis in the current bureaucracy.

This is not to criticise choice in the NHS — both choice of treatment and choice of doctor, where possible, add to the effectiveness and humanity of the system. It is to point out how making this consumer–based approach to an ideal is getting in the way of real change taking place, by raising public expectations of more flexibility choices of "product", and by encouraging a self-image by patients as passive and amoral shoppers, flitting from institution to institution in search of the best deal.

But this is not the only contradiction. The Government's laudable but flawed efforts to involve people in their local hospitals, via Foundation Trusts and similar policies, fly in the face of the consumer–based approach. If NHS patients are consumers facing a multiplicity of choices provided by the market, there is no reason for them to take any more interest in one local hospital rather than in another.

Of course, the label of consumer is also intended to signify that patients have some autonomy in the face of the giant national health system, still the biggest employer in Europe. It is supposed to demonstrate that they are individuals, with dignity and rights. That is an important task. But the consumer–based approach is not the only way of demonstrating this change. In fact, the contrast between the rhetoric and the reality may actually be having the opposite effect.

This report sets out a brief analysis of where the Government's NHS reform has gone wrong, and why it will fail. And it sets out a new approach that can make a difference — an **asset–based approach** that recognises that patients and staff are hidden assets that the NHS is failing to engage, and that costs are increasing disastrously because they are failing.

The asset–based approach, known as "co-production" in the USA, could be applied equally to all public services. But the NHS, where the structural problems seem so intractable, and where constant re-organisations of structure and language have exhausted and demoralised staff without obvious improvement, is one area where it is urgently needed.

An asset–based approach

> *"Effective public engagement will require an active partnership between those who provide care and those who receive it. The traditional relationship has been a passive one, which can be characterised by health professionals providing care to a generally deferential and uninvolved public, based on an underlying assumption that medicine, and those who practice it, can solve all medical problems."*
>
> **Derek Wanless, *Securing Our Future Health***

Half a century ago, Britain was united by a range of institutions that held together what was then as now a diverse society. There was the BBC and one television channel. There was national service, which gave every male a common experience of other classes and other possibilities. And there was the NHS: cutting across all classes and reaching into every corner of the nation. People may have relied on private healthcare if they could afford it, but it was rare for them to have no experience at all of NHS provision.

Now, 50 years later, that common experience has almost completely disappeared. There are hundreds of competing TV channels, national service has long gone, and most of the other ubiquitous experiences that held British people together across the classes have been replaced by competing brands and demarcations.

But the NHS remains. And though the necessary queuing before and during appointments seems a shadow from an age when queuing was more ubiquitous, it does still treat almost everyone at some time of their life. Despite the grafting onto the NHS over the past decade of consumer rhetoric, and the regular media criticism of the work of frontline NHS staff, actually people's experience of their work is overwhelmingly positive. The survival of the public service tradition from half a century ago is still delivering, despite the re-organisations, the targets and the raised expectations.

It is also absolutely vital that it does so. Because that public service tradition, involving NHS staff at every level of the organisation, is one of the most effective assets that the NHS possesses — the deep knowledge of staff, doctors, nurses, and managers, who are dealing with patients every day and making the system work for them. They are, of course, valued as central to the future of the Health Service, yet their ability to use their own judgement, and to use their responsibility, has been increasingly curtailed.

The second critical asset — and just as undervalued — is the potential for involvement of patients in their own healthcare, and that of their family and neighbours. The Wanless Report concludes that the NHS could survive and

thrive only if people took responsibility for their own health: the Government has yet to understand the implications of this.[1] John Reid's public health consultation talks about the challenge of 17.5 million people in the UK suffering from chronic disease. Yet the NHS instinctively seems to fall back on small experiments with time banks and expert patient schemes, and on threats — for example that people might be fined if they were overweight — rather than building on this asset and making sure it works.

Forgotten assets

An asset–based approach implies that policy-makers and ministers can look afresh at the NHS — not just at the target outcomes and certainly not just at the balance sheets — to discover that patients and staff are actually the most important assets the NHS possesses, and the only two likely to deliver better health on the ground.

The asset–based approach makes use of those in appropriate ways in using a range of reciprocal tools — not the traditional model where exhausted professionals "deliver" health to grateful and passive patients, but one where frontline staff and patients are engaged in such a way that they can deliver what the NHS requires to heal and keep people well.

Consumerism does not achieve this — though the asset–based approach is certainly not anti-choice — because consumerism suggests that patients have no duties, no responsibilities, and that staff are simply cogs that deliver specific outcomes. Any policy approach that ignores the critical importance that long–term relationships, between patients and supportive neighbours or between patients and doctors, have to healing and staying well — and an over-emphasis on consumerism is one of these — is bound to make the NHS more expensive and less effective.

Experience in various public services around the world suggests that, not only is co-production and the asset–based approach extremely effective — but also, by unlocking these forgotten assets, these improvements can save considerable amounts of money without making staff redundant or cutting services. They do so by making the efforts of managers, staff and patients alike more effective.

Valuing patients

> "*If in the past decade the NHS has come to understand that health services are immeasurably improved by the patient voice, in the next 20 we will come to understand that they can only be delivered with the citizen's hand."*
>
> **Paul Hodgkin, *From Disability to Competitive Advantage*[2]**

There is a growing — though not yet universal — understanding of just how much healthcare depends on the co-operation of patients. Doctors complain that it is hard to get patients to change their lifestyles, eating habits, lack of exercise or smoking addiction. Alcohol and drug rehabilitation programmes can't work without the enthusiastic co-operation of the people involved. The Wanless Report emphasises this critical aspect of funding the NHS. It points out that unless people felt responsible for maintaining their own health with NHS support then the future of health funding is bleak.[3]

It is also becoming increasingly clear that people's sense of responsibility needs to go beyond their own health, and that a supportive community is an absolutely critical NHS asset which can considerably reduce costs. Take bypass surgery or hip replacements, for example. Patients will recover faster with some kind of support group who makes sure they are not lonely, that they have food in the house, and that they have somebody to turn to if they succumb to depression.

Social capital

Meanwhile, the evidence is growing that social capital — one of the outcomes of getting involved with other people (friends, relatives or community groups) — is good for your health. Analysis of 7,000 Californians showed that "people who lacked social and community ties were more likely to die in the follow-up period than those with more extensive contacts… The association between social ties and mortality was found to be independent of self–reported physical health status."[4] The work of the sociologist Robert Putnam also demonstrates the dramatic health effects of social links.[5]

A survey of coronary heart disease in middle–aged Swedish men demonstrated that lack of emotional support from very close persons ("attachment") and the support provided by the extended network ("social integration") posed almost as high a risk as smoking.[6] And one of Ichiro Kawachi's numerous studies of the subject, looking at the causes of death or illness in over 32,000 men, concludes that "social networks were associated with lower total mortality by reducing deaths from cardiovascular disease and accidents/suicides".[7]

This has an obvious effect on the costs of the NHS. A classic example is the problem of finding appropriate care for older people in the community so that hospitals can send them home. Birmingham Royal Infirmary suffered from severe bed-blockage during the winter of 2000/2001 and cancelled all elective surgery, simply because they could not send older people home — because there was no-one to look after them.[8] Similarly, patients who are discharged from hospital and go home alone where there is no food in the house are believed to be more likely to be readmitted. Experiments in the USA have shown that setting up support groups of patients with asthma — who befriend new patients over the phone (and earn time credits in recognition, see below) — can reduce the costs of treating asthma by over 70 per cent, simply by keeping asthmatics out of casualty departments.[9]

It seems obvious that social networks can make an enormous difference to the costs of keeping people well and curing them when they are ill. Yet the prevailing trend in UK health rhetoric has been in precisely the opposite direction. It has allowed patients to believe their active involvement in their own or other's healthcare was somehow irrelevant. It has encouraged a growing divide between an increasingly pressurised and exhausted professional staff and increasingly disempowered and passive patients, for whom time hangs heavy.

Patients at the centre

It is a trend that is recreating the NHS in the image of a wider welfare system that insists that people demonstrate that they have ongoing problems before they can get support, which categorises people according to their disabilities and remains disinterested in their abilities. When Public Health Minister Hazel Blears talked about reintroducing “an element of reciprocity”, she was talking about tackling the corrosive situation where all elements of reciprocity have been ironed out in the name of professional status.[10]

It follows that the failure of successive governments to find agendas to actively engage patients in mutual support has meant that funding the NHS has cost more than it needs to. This is so because the involvement of patients and supportive communities has not been sought, and because they are now hard to engage at all. The NHS has been considerably less effective as a result.

It is true that the Department of Health has strongly pushed the idea of a patient–centred NHS, and that this is now a central strand of NHS strategy. There are programmes for public involvement and public health. The strands of government health policy that grasp the importance of patient involvement have been responsible for a range of policies that, at least initially, were claimed to devolve power to local people. These include:

- **Foundation Trusts:** These are initiatives modelled on some of the proposals for a more mutual state apparatus that have been developed by **nef** (the new economics foundation). The idea was to provide hospitals with mutual management and an element of local control — and the ability to raise their own finance — that could set hospitals free to some extent of Whitehall control. In reality, however, the mutual element has been reduced to limited community membership, with an irrelevant right to elect an advisory body, with their exact roles to be determined by each trusts’ constitution. Proposals for increasing participation by patients have been set aside by all the original foundation trust managers. This a serious omission: handing over financial powers to local managers, without passing on accountability to

patients, staff and local people, is simply creating a new generation of unrepresentative fiefdoms — and this is already leading to a general backlash against participation. If the resulting advisory boards are unrepresentative, as critics fear, that is a direct result of failing to give them responsibility.

- **Patient Forums:** Initial experience shows that the Government's recruitment of ordinary patients onto the so-called Patient Forums — organised under the auspices of the NHS appointments commission — has been disappointing: although the Commission for Patient and Public Involvement in Health described "huge numbers" that had applied before their launch in December 2003, actually the total was a little over 4,000 for the required 4,560 for 575 patient forums.[11] But the real test will be when it becomes clear how sustainable that involvement is. There is little evidence that policy-makers have thought this through. And the experience of representation on other health bodies suggests that what is billed as "participation" is in fact the same few "professional" representatives who turn up time after time, representing nobody.
- **Primary Care Trusts (PCTs):** The governance of PCTs is not determined by a "national model". In theory, there is a lay majority on the governing panels, called Trust Boards. The PCT aims to tackle health issues through joining up local authority and voluntary group participation too. The difficulty, again, is sustaining public interest in running bodies that are seriously constrained by central targets, and in professional services that they have little or no role in delivering.
- **Expert Patients Initiative:** Evaluation shows that this approach, which enables patients to develop the necessary skills and knowledge to manage their own chronic health conditions, is remarkably effective but has still to be made available on a national basis, and will not be national until 2007.[12]

There is also a continuing tradition of volunteering in health services, through the League of Friends and the Women's Royal Voluntary Service, helping to provide a friendly face or a cup of tea when it is most needed. But time-giving in hospitals is declining. The number of hours volunteered has declined from 30,500 hours per trust in 1995/6 to 27,000 in 1997/8 as the core group of volunteers dwindle, mostly women in their 70s and 80s. The number of trusts employing a manager of volunteers is also declining.[13] Hospital trusts are often keen to involve more volunteers but are at a loss about how to attract new kinds of volunteers from among younger or working people.

Participation not enough

The problem is that policy-makers have yet to grasp that participation — if it is to mean anything, and if participating patients are to become the assets the NHS needs — has to go beyond the simple business of getting token representatives onto committees, or creating token committees: it has to go beyond mere consultation. For participation to access the resources that patients represent, there needs to be a framework whereby they can be active alongside health professionals, and whereby this effort can be recognised.

The main place within the health service where people are getting more involved is through patient–support groups. These use new knowledge to challenge the medical establishment where necessary and to provide valuable support to others who are managing a similar condition. The benefits of peer support approaches within health are now well recognised.

The Expert Patient programme has been incorporated into the Department of Health's Patient Involvement Strategy (*see above*). Long–Term Medical Alliance, an umbrella organisation for groups working with long–term medical conditions, has been working with the idea since 1998. Volunteers with long–term medical conditions have been trained to become tutors for other patients through self–management training, aimed at making sure that patients are as active as possible in the treatment of their own condition.

One of the most important innovations has been the advent of time banks in health — the first one at the GP surgery in Rushey Green in south east London — and building on experience of similar projects in the USA and Japan. This measures and rewards the efforts patients put in for the local community, which might include visiting, telephoning, doing basic repairs and the range of services that doctors know are needed but which nobody is funded to provide — and which anyway are better provided by neighbours than by overstretched and anonymous professionals.

Recovery support

The exact financial advantages to the practice of running the time bank are currently being studied by a team from Guy's Hospital, but it is already clear that it is capable of providing valuable recovery support. This applies not just to those patients who are helped but also the helpers: it can reduce the medication they need. For example, for those suffering from long–term depression, simply providing them with a sense of useful work and connection with others can improve their health.[14]

The Expert Patient programme in Sheffield has now linked up with the Darnell Healthy Time Bank so that expert patients who give their time to tutor others with long–term conditions will be able to get their time back as vouchers from local health centres or fresh fruit from local shops. Research has also shown that time banks are uniquely capable of reaching some of the hardest–to–reach groups that volunteering normally fails to involve, including black and ethnic minorities, those with mental health problems and disabilities, and the housebound elderly.[15]

There are a range of other initiatives around the UK, ranging from the Patient Involvement workers employed by the Lothian Health Council and Lothian Health Board, to the time banks set up by the South London and Maudsley NHS Trust (SLAM) as a way of “designing-in” patient involvement so that it forms an integral part of service delivery. But these are small initiatives and come nowhere near their full potential if the NHS was to roll them out nationwide and, by doing so, give priority to accessing the assets that their patients represent.

NHS response

The NHS is in a difficult position. The emphasis on patient involvement is constantly challenged by the capacity of staff and the resources available. By themselves, NHS professionals can have no impact on the better employment prospects, better eating, better housing, better attitudes to life that lie behind so much of the ill-health they are expected to tackle. There is also a frustrating reluctance by the public to be involved in the preferred way — as a representative on an advisory body.

The drawbacks of a “communitarian approach” are that it pinpoints the need for social capital and responsibility, but fails to specify policies that might achieve it. This tendency runs throughout New Labour policy and was particularly apparent in the Health Secretary’s speech of 3 February

2004. Without these policies, governments fall back on rhetoric and threats against smokers or the obese, in ineffective bids to bring them into line.

This is not a solution. In contrast, the asset–based approach does indicate a way forward, where local trusts want it. Time banks and other co-production techniques allow them to reach out into the wider community and start to make a wider difference.

Valuing staff

"People...in enterprise, in government...are by and large well intentioned. They'd like to get things done. To be of service to others. But they're thwarted...at every step of the way...by absurd organisational barriers...and by the egos of petty tyrants."

Tom Peters, *Re-imagine!*[16]

Research by **nef** has shown that there is some suspicion of patient participation schemes among the NHS staff who would have to make them work. This is often because no such participation in the running of health services has been offered to them.[17]

Participation anyway tends to get lost among all the other demands on the time of NHS personnel partly because — by its very nature — it is difficult to sum up in measurable deliverables, and can get crowded out by objectives that can be summed up in that way. Mainstream, centralised measuring leaves little room for participatory approaches, whether by patients or staff, that deliver health impacts above or below the radar.

Target culture

This is a symptom of the basic problem. The target culture remains with us in the NHS and it is a manifestation of the basic distrust that Government has in frontline NHS staff. According to a survey by the Audit Commission in May 2003, the British public has the highest trust in NHS than any other institution, with 79 per cent of the public trusting their hospitals "a great deal"[18] This level of trust clearly isn't shared by their employers.

Nor is the target culture effective in making change happen. Many of the imposed targets simply complicate the clinical requirements of individual patients, who are then used as pawns in the battle by managers to meet their targets. There are also ludicrous examples of targets that have the opposite effect to that intended, like the target designed to measure the time patients take between being seen and getting treatment in casualty. The result was, for one 88-year-old, a 24-hour wait to be seen, officially recorded as 30 minutes. Other hospitals have been reported as avoiding the target that limits patients' period on hospital trolleys to less than four hours by putting them in chairs instead. Others have bought more expensive kinds of trolleys and re-designated them as "mobile beds".[19]

The most ludicrous example of a political target is the idea, set out by former Health Secretary Alan Milburn, that the NHS is more successful if it gives out more prescriptions.[20] This falls into exactly the trap of a consumer–based NHS: a health service that feels successful because it gives out more prescriptions is one that is more expensive to run and less

effective. As any GP will confirm, people's problems are often not best treated by drugs.

The truth, according to Goodhart's Law, is that numerical targets designed as a means of controlling staff will be inaccurate because they are subverted. Because what is critically important is not amenable to numbers in this way, the targets will always miss the point — as they did with the waiting-list targets that were abandoned because they favoured patients requiring small operations over those requiring big ones.[21]

Worse, health problems that are amenable to drug therapy or simple surgery are bound to be prioritised by a target culture, because they are easy to measure, and at the expense of chronic problems that require complex (though simple) interventions by frontline staff, patients or neighbours. It is not surprising, therefore, that chronic health problems are on the increase — and it is clear then that it might be possible in a target–culture NHS that ignores its key assets, for the health service to meet its narrow targets but cost considerably more to run.

Frontline staff

The complexity of the people that frontline staff see before them can never be summed up in figures. No target will be adequate to deal with human beings, who by their very nature will always step outside neat categories, and statistical probabilities about the effectiveness of treatment may not be useful when it comes to deciding the treatment for a specific patient.[22] The NHS stands or falls by the experience and skill of the frontline staff, and the public service ethos that motivates them, despite the pay and conditions, to make the system work. If frontline staff succeed, the NHS will succeed. If they fail, then no amount of targets and no amount of administrative reorganisation will turn that situation around. The solution is to empower the frontline staff.

One heart–rending example of this in practice is the experience of the historian and Liberal Democrat peer Earl Russell, whose wife attended A&E complaining of headaches. Because staff were prepared to break their targets and spend six hours with her there and then, they were able to diagnose inoperable brain cancer. If they had kept to the four–hour target it would have meant a number of subsequent out-patient appointments to discover the same thing, at considerably greater cost and greater emotional upset for the people involved. Because they were prepared to break the targets, they were able to save money and heartache.

Misunderstanding the lessons of privatisation

Ironically, this lesson has been learned by successive governments when it comes to encouraging business: the solution is to empower the only people who can make it happen, the entrepreneur and business risk-taker, who best know what is required. But for some reason, this lesson has been extrapolated to the public services in boulderised form: that business skills and know-how should be brought to bear on NHS administration — either in terms of privatisation or consumer rhetoric — as if it was a business. Both of those may have their place in the NHS — this is not a diatribe against privatisation — but they are irrelevant to the basic issue. The important lesson from business, and the real lesson of privatisation, is that it is vital to empower the staff who have the experience, take the risks and make things happen.

The lesson of the business world in public services is not to bring in a different culture; it is again to empower the only people who can make it work. Business consultant Sid Joynson estimates that productivity

increases of up to 40 per cent are available to businesses that successfully empower their frontline staff.[23] Business itself has learned this lesson; the NHS has not.

Patients get better faster in a supportive community, and when some London hospitals have a nursing staff turnover of 38 per cent per year, that is far harder to build inside NHS institutions.[24] Some of this problem is to do with high house prices and other difficulties about living and working in London, but some is also how NHS managers organise staff. The Audit Commission found recently that more than half the variation in turnover rates is explained by differences in how trusts manage their staff.[25]

Valuing staff without empowering them

It is true that new contracts and new NHS staffing strategies, as well as the introduction of line management and regular appraisals, are making some progress in improving the satisfaction of NHS staff. But the culture is still antithetical to empowering them. While it is possible to point to a series of local experiments involving patients and other stakeholders in the running of the NHS at a local level, there are almost no examples of similar experiments involving staff.[26] Again, this flies in the face of mainstream business experience.

The exception could have been Foundation Hospitals, had these been a genuine experiment in mutual health. Unfortunately, it is now clear that, even if there is adequate mutual ownership that fully involves staff democratically in the running of their institution, that will not unlock the hidden assets that the NHS staff represent if they are still constrained. These constraints can come from the target culture controlled from Whitehall, or the strict demarcations between different professional boundaries, or the different bureaucratic boundaries between jurisdictions that artificially divide different aspects of health, and hand them to other parts of the state apparatus that do not necessarily communicate.

Empowering frontline staff means making career structures more flexible, giving more authority to staff who see patients, giving them discretionary powers and discretionary budgets that allow them to short-circuit long–term bureaucracy if necessary. At the very least, health targets need to be simplified and redefined so that they encourage rather than exclude participation, and so that the hidden assets in staff and patients can be used efficiently. The public service “ethos”, still alive in the NHS, is a vital money–saving asset that must be used.

Tackling giantism

> *"Social support, connection, community or social capital, call it what you will. At heart it means that when you feel loved, nurtured or cared for you are much more likely to be happier and healthier. You have a much lower risk of ill-health. If you do get ill you will have a better chance of getting well again and a quicker recovery."*
>
> **Dean Ornish, *Love and Survival*** [27]

Accessing the hidden assets of staff and patients is not a new idea for many people in the NHS. Staff will confirm their importance, just as managers will describe the repeated reorganisations — often revisiting old shapes from decades before — which still find it difficult to provide the kind of responsiveness that Whitehall requires. The protectiveness of professional groups and the sheer complexity of the system, makes many of those involved in it feel powerless to change it. But this tradition of the NHS has been recognised as a core problem recently, not least by Public Health Minister Hazel Blears when she described many people's view of the NHS as a "monolithic monopoly with all the power concentrated centrally, without obligation to people or place".[28] Current government policy certainly recognises these issues.

But one issue above all prevents these assets being used to the full: it is the misplaced drive towards giant institutions, in the name of financial efficiency that isn't actually very efficient at all.

Service centralisation

The last generation has seen a consistent centralisation of services into increasingly large hospitals and other giant institutions. This has been carried out in the name of efficiency, and has been backed by some NHS groups on the grounds that it gives more patients the benefits of the best experts and the top personnel. In 2002 alone, 60 local and cottage hospitals were closed, and the burden of closures has fallen particularly heavily on people who rely on public transport.

In fact, the key motivation behind, for example, the centralising of three hospitals on one site in the case of the Chelsea and Westminster Hospital in London — and similar schemes elsewhere in the country — has been the windfall profits for the Treasury on prime sites sold as one-off windfalls in the open market. NHS staff have been increasingly reluctant to work in these factory institutions, on the grounds that they are even more disempowered than before — and because it is hard to relate to patients or

fellow staff in institutions of that scale. A large hospital like Leeds General now employs an astonishing 12,000 staff and up to 40 different units.

Staff at the internationally–known Harefield Hospital in Hillingdon reacted furiously to the news that they are expected to transfer to a monster institution, closing their own hospital and moving onto a site by the Paddington Basin as part of a £360 million development that will include three giant hospitals. The prospect of becoming cogs in a giant machine has been a major part of their campaign.

The different meanings of efficiency

But "efficiency" is a slippery concept, and what might be efficient financially is often not at all efficient in other ways. Big institutions mean that savings can be made in purchasing — but these savings are often lost again by the sheer wastage in institutions where staff feel they have no stake. Nor is patient care going to be optimised if patients never see the same doctor twice during their stay in hospital — however expert those doctors might be.

The result of centralisation into giant institutions is a series of externalities that raises the cost of the NHS to run, in costly mistakes or in the generation of dangerous hospital bugs that thrive in the biggest institutions. It is no coincidence that the number of deaths caused by medication errors is rising, and this already costs the NHS £500 million per year — or £1.1 billion including adverse reactions to drugs.[29] The impact of hospital bugs is even greater. Up to 5,000 people per year die from infections caught in hospitals, and they are now affecting 100,000 people per year at a cost of £1 billion.[30]

The diseconomies of scale are particularly apparent when it is clear that one person in 10 who is admitted to a UK hospital now ends up suffering "measurable harm" — whether it is from mistakes, bugs, faulty equipment, or drug side-effects. Additional hospital stays as a result are valued at £2 billion per year.[31] The National Patient Safety Agency is working on these issues.

These enormous and preventable costs are a direct result of giantism, of disconnecting staff from patients, of lack of ownership, of alienation and the burden of extra management that enormous institutions entail. They also mean less chance of bringing to bear the wasted assets of patients and staff.

There is some recognition among ministers that scale is important. The advent of Primary Care Trusts (PCTs) in April 2002 was intended as an attempt to devolve commissioning of primary health closer to patients. But PCTs are still a product of that same mind-set that leaves ultimate power in the hands of those at the centre.

To be fair, the consumer ideal has been the impetus behind the revival of smaller hospitals and treatment centres. But again the giant bureaucratic systems required, even to give the illusion of choice, have left staff at the mercy of forces and targets that are entirely outside their control, and which relegate their experience and judgement as frontline staff below regional or national standards and policy systems.

Co-production

"Money, philanthropy, programmes alone can't cure social problems if we can't enlist those being helped as partners and co-workers. And the way to send that message is by honouring the contribution that people can make by enabling it to confer the ability to secure the essentials to life."

Edgar Cahn, Time Dollar Institute

The asset–based approach to the NHS, as it is to all public services, is based on the understanding that there are wasted assets that can tackle these vast and growing diseconomies of scale — both in and around health institutions — and that these assets are actually enormous.

The idea that health can be a partnership between staff, patients and community is summed up in the term "co-production", an idea that originated in the University of Indiana as a way of describing what was missing from urban policing when it became unable to engage with the public. It was a way of describing a solution, not just in policing but in all public services — a joint responsibility shared between professionals and clients.[32] Co-production is the process whereby professionals work alongside their clients in order to be effective.

The development of a concept

Co-production provides a critique of large health programmes that reveal how they tend to impact only on day-to-day symptoms. Worse, that all too often the professionals are simply creating dependency — but a dependency of a peculiarly corrosive kind: one that convinces patients they have nothing worthwhile to offer, and which undermines what systems of local support that do still exist.

Actually, the opposite is true: patients are assets — with life experience and the ability to care, and often with time on their hands that they would only too willingly give if there were institutions that could manage it. The Indiana University team that developed these ideas, under Professor Elinor Ostrom, believed the original confusion arose because of a myth that services were neatly demarcated between agencies and sectors, when the truth was that a variety of interlocking services were responsible for different aspects of the same problems — and there was no real divide between public sector agencies and clients.[33]

Since then, the concept has been refined and developed by the work of the law professor and co-founder of the US National Legal Services Programme, Edgar Cahn. For Cahn, "co-production" means that — if professionals are going to succeed in the long-term — welfare

programmes, policing or health, need to be partnerships between professionals and clients that respect what both sides need to provide. That requires systems that can broaden our definition of work, and which allow the people who are normally the object of volunteering or health services to be actively engaged in providing mutual support — which can both broaden the way work is understood and be transformative for the people taking part.[34]

Meaningful responsibility

Co-production is not intended as an ideal that professionals simply need to aspire to. Nor is it simple consultation with clients, or asking people's opinion, or even basic participation in decision-making. All that has been tried and it either isn't enough, or it is used as a method of further coercing patients and staff — or to tick the target that requires “user involvement”. It means that patients and professionals have to be partners in the business of their own regeneration, and in the delivery of care — in such a way that they and others can be embedded into a new community that will be there when they need it, and can insulate them from further illness. Co-production gives responsibility to patients, and helps those patients feel useful and worthwhile when long–term illness sometimes categorises them as useless — and by so doing, changes their lives. Experience has shown this can have a dramatic effect both on their recovery and their need for medication.[35]

Co-production has an important track record in health, for example in the cost–effective solution to the intractable problem of multi-drug resistant TB in inner cities and developing countries — where the cost of hospitalising sufferers to make sure they take the full course of the expensive drug cocktail that is necessary make a cure almost prohibitive. Co-production allowed health professionals in the Boston–based programme Partners in Health to design a programme whereby drugs could be delivered at home and the administration checked by neighbours and other patients.

Co-production in practice

Co-production is often, but not always, associated with the work of time banks — which can provide a framework whereby patients are asked for help, and their efforts in the community are measured and rewarded with the use of time credits. Time banks have an important track record also in co-producing education and justice, whereby problem teenagers are engaged and drawn into the business of reinforcing study and good behaviour by giving them responsibilities. This is an approach that originated in the USA. In St Louis, in the seven health centres run by the Grace Hill Settlement, doctor's bills can be paid in time credits earned by making a contribution in the neighbourhood. Similar programmes are under development in El Paso and other places. In Rushey Green, and other health time banks in the UK, research shows that involvement in the programme can have a dramatic effect on health. This is especially so for people with long–term depression or people who have both physical and mental difficulties.[36]

There is no doubt that, despite its appeal and its ability to shift intractable social problems, co-production remains controversial among some professionals. Big agencies find these ideas hard to grasp because it often means changing procedures and ways of working that can be resisted by large bureaucracies simply because it conflicts with some existing methods. There are also fears about handing over responsibility to clients who have been defined hitherto by their problems rather than their capabilities. Many professionals have been trained to believe that this would be irresponsible,

and need to be reassured that systems will be in place to safeguard their clients and those they will be working with.

The targets many NHS institutions have to work to expect them to measure their success according to very basic numbers, so often it is not immediately clear to agencies how useful — in the narrowest possible sense — co-production is for managers. There is also an inevitable fear among staff, especially hourly–paid ones, that handing over tasks to clients and participants will make them less essential to their employers. They need to be reassured that they have an unassailable but different role to play, and that the tasks carried out by participants — providing a friend to neighbours, for example — are usually not the kind of jobs that professionals are best at doing. There are considerable efficiencies that will result from co-production: Staff need to be reassured that this will make their service provide better, deeper change in the lives of those it helps.

Co-production in health means that patients and professionals become the core drivers of reform and progress in the NHS, based on a reciprocal relationship between them. It means that patients are able to rely on supportive networks of peers and neighbours, and are rewarded for their local knowledge and effort. It means that staff and patients are able to undertake long-term strategies to address underlying problems. Examples of asset–based strategies in health include the following:[37]

- **General practice:** The Rushey Green Group Practice in London is able, in effect, to give prescriptions to patients for friendly visits, small repairs or other forms of social support if these are more appropriate than drugs. They do this by running a time bank on the premises that involves patients of all races in the multi-ethnic neighbourhood of Catford. It is already clear that patients who are time bank participants visit the surgery less and, especially in the case of long–term depression, rely less on drugs.
- **Hospital aftercare:** The Rest Assured scheme, run through the Fair Shares network of time banks in Gloucestershire, guarantees participants that if they have an accident or unexpected stay in hospital, they will be visited by people who will do their shopping and provide other help for up to two weeks after they return home.
- **Health promotion:** The Gorbals Time Bank in Glasgow runs a fresh food delivery service, and is among a number of time banks linked to health. Among those providing support for healthy living are the time banks network run by the Agency for Health Enterprise and Development in Sandwell.
- **Health education:** The Member-Organised Resource Exchange (MORE), part of the Grace Hill Settlement in St Louis, organises a time bank for over 12,000 members, and can pay in time credits — earned supporting neighbours — for doctor's appointments and a range of health education and other courses.
- **Community care:** The Member-to-Member scheme run by the health insurance company Elderplan in New York organises peer counselling, arthritis and diabetes self-help groups and a range of other support systems through a time bank — allowing participants to use time credits earned locally in return for theatre tickets or restaurant meals donated by local business.
- **Expert patients**: The Sentara group of hospitals in Richmond, Virginia, made dramatic cost savings in the treatment of asthma —

including a 74 per cent cut in hospital admissions — by organising asthma patients into a telephone support system run through a time bank.

- **Mental health:** The Cares of Life project, run through the South London and Maudsley NHS Trust, has time banks and co-production at the heart of its efforts towards the minority ethnic population of south east London, recognising the critical importance of self-esteem and social networks in recovery from mental ill-health.

Potential cost savings

The cost savings if this asset–based approach was made mainstream in the NHS are hard to calculate, but it is clear that it would make a major impact on the costs of bed-blocking (one in five beds are now filled by people who should not be in hospital at a cost of £1,200 a week), emergency readmissions (there are now more than 520,000 of these), chronic problems like asthma, diabetes and depression, and in social care by enabling older people to live in their own homes for longer. The Wanless Report estimates that investment in public health and public engagement might save the NHS £30 billion per year by 2022, which is half the current budget of the NHS.[38]

The World Health Organisation(WHO) estimates that healthy life expectancy in Britain could be raised by around 5.4 per cent by successfully tackling the problems of irregular blood pressure, high cholesterol, obesity, tobacco and alcohol — and this can only be done by recognising the responsibility of patients.[39]

The potential savings are clear. What is not clear in any of these estimates is what mechanisms can be used that could make it possible in practice. The asset–based NHS is the strategy that is required. It makes other achievements possible, for example a strategy for motivating and inspiring people to increase exercise by 10 per cent, which could save 6,000 lives per year and another £500 million.[40]

Experience at Rushey Green suggests that 70 per cent of participants who were experiencing a combination of physical and mental difficulties — the most expensive people to treat in primary care — felt some remission within six months of joining the time bank at the surgery.[41] Research by Elderplan into the cost effectiveness of their time bank programme showed a clear correlation between lower levels of loneliness and health — in particular fewer prescriptions and fewer hospitalisations. Other investigations in the USA suggest that time dollar programmes have a return on investment of about 6:1.[42] Equivalent UK figures assume that each hour of donated time provides an injection into the economy of about £10.42 per hour.[43] That would mean that even at this early stage, a small time bank like the one at Rushey Green paying for itself quite easily, and having considerable knock-on effects in savings on drugs and ill-health.

Exactly what those savings are will have to wait for more detailed research. But the costs just of treating diabetes, asthma and depression (£6.3 billion per year), the cost of bed-blocking (£170 million) and the cost of delayed discharge (£3.6 billion) are all amenable to this community–based approach. It seems likely that the emergency readmissions rate can also be dramatically reduced.

Studies in North America show that the return on investment in health promotion and volunteering range between 2.3:1[44] and 6.8:1[45]. There is some confirmation for this in studies of health promotion schemes inside company health plans in Canada, which shows returns on investment of

between 3:1 and 7:1.[46] Studies in the USA about investment in mental health promotion come up with similar figures.[47] This suggests that investment in time banks or other co-production systems could save the NHS considerable sums: Making serious investments in this kind of infrastructure in the largest 5,000 GP practices might cost around £1.2 billion — not all new money, since many of them are already employing people in similar roles — but this would mean knock-on savings in NHS spending of between £3.6 and £8.4 billion.

Home Office research suggests that 67 per cent of the UK population volunteered informally, and 39 per cent formally, sometime during 2001.[48] That suggests that the scope for expanding the asset–based approach effectively within the NHS is certainly there.

Conclusion

"Time banks stimulate participants to become more knowledgeable about their own health, more empowered when confronting the healthcare system; and more adherent with their medical regimens."

Dr Richard Rockefeller, Doctors Without Borders (Medicins Sans Frontieres)

The trouble with the consumer–based model for the NHS is that patients are not consumers at all. They often have very little choice but to trust their local NHS staff and do what they can to recover or mitigate their health problems. The hard–to–reach groups remain hard to reach, and the costs continue to rise. Those rising costs, that intractability, are likely to be the final nail in the coffin of a model that simply doesn't work. All the evidence is that resources are still not trickling down through the system to provide benefits for the poorest patients. More money in the system may do little to iron out the inequalities in the NHS: A baby boy born in the deprived London borough of Newham has a life expectancy six years lower than one born a few miles to the west in wealthy Westminster.[49]

This failure is of course a direct result of economic disparities and issues of wealth distribution. Poverty is still the world's biggest killer. But it is also a problem of giantism, of the hidden externalities of large institutions, and the failure to engage the forgotten assets in patients and staff. The solution is not necessarily more money, but systems of mutuality — both to manage the NHS locally and to "co-produce" health solutions between staff and patients.

The NHS needs a programme that introduces co-production at every level, with the emphasis on primary care — engaging patients in delivering care, whether they are themselves suffering from mental health problems, or disabled, or bedridden, but finding that the sense of being valued for what they can give can also transform their own status.

The evidence is that time banks and other forms of co-production more than pay for themselves in the health improvements of those involved. But co-operation between empowered patients and disempowered staff makes no sense. Co-production will be effective only when staff have their own systems of mutual ownership of their local institutions that are meaningful and effective.

Both of these also depend on a new generation of human–scale institutions that can deliver healthcare in the NHS. We therefore propose that the NHS should:

1. Launch co-production training for NHS frontline staff: Using patients as assets requires a new approach to work. That means more organisational support for those NHS bodies — especially at primary care level — where the majority of NHS training and development takes place, and which are keen to engage with local communities but lack the time, money and incentives to do so.
2. Insist that every health institution has some system in place to involve patients as partners in the business of delivering health.
3. Put more emphasis on smaller–scale health enterprises, shifting the current focus on large–scale institutions. “Cottage–hospital” style approaches are more popular with patients and more successful in developing working partnerships with local communities.
4. Invest, research and commit to disease prevention and public health promotion — as opposed to focusing purely on technical solutions to ill-health — but concentrating on approaches beyond the conventional public health “solutions” of education and communitarian–style disincentives.
5. Set up a national database of best practice to develop staff resources.
6. Give institutions freedom to set locally agreed health targets in response to local need.
7. Fund research and pilot projects that involve patients and local people in specialist areas like tackling diabetes, asthma, arthritis, bereavement, and depression — along the lines pioneered in the USA.
8. Pioneer ways that allow the cost savings through greater effectiveness to be drawn forward to fund projects like time banks and expert patient schemes.
9. Give frontline staff discretionary powers and budgets that allow them to short-circuit long–term bureaucracy if necessary.

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