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**Check against delivery**

Thank you for the opportunity to speak to you today.

In its first 15 years, the NHS Confederation has grown into an organisation of real influence.

Always voice of reason and balance in the frenetic healthcare debate.

But strong when it needs to be, unifying the NHS.

Huge achievements and, of course, all down to the year I spent as your Parliamentary Officer in 1998.

Back then, we were planning for the service’s 50th anniversary; as we meet today, we are less than one month from its 65th.

All things considered, those 15 years have been one of the strongest periods in its history.

I recall the debate running into the 50th – and indeed the 1997 General Election – was more about whether the NHS could survive in its current form.

Its revival since then is perhaps illustrated no better by the fact that it barely featured as an issue at any the last three General Elections.

But that won’t be the case at the next one. Indeed, I’m on a mission to make it so.

I think we’re reaching a fork in the road moment.

The 21st century is asking questions of our of 20th century health service that, increasingly, it is not able to answer to the public’s satisfaction.

We need to decide what kind of health and care system we want in the century of the ageing society.

The problem is the Coalition has come up with the wrong answer.

Now, I know what you’re all thinking: “Oh god. Here we go. Another re-organisation.”

As you may have seen, I have given speeches before in Liverpool with thousands of people heckling and booing me.

I was hoping that history wouldn’t be repeating itself today.

As you will hear, I think I can reassure you on the R word.

I fully understand the cynicism that people in the health service have for political grand plans – often dropped on them without warning five minutes before a General Election or, in the case of the current one, five minutes after.

And I hear those voices that say – can’t they just agree across the parties a basic vision for the NHS and then let us get on with it?

I agree – that would be the ideal.

And, at the last Election, it looked for all the world like it had finally been achieved with both sides promising ‘no top-down re-organisation’.

Then came the bombshell of the Health and Social Care Bill.

David Nicholson was right to say yesterday that it distracted the service at the worst possible time.

But my problem is this – I can’t leave things as they are.

That doesn’t mean I need new organisations to do what I want to do. The terrible irony is that politicians rarely do.

Just as the last Secretary of State could have re-shaped PCTs – slimmed them down, put doctors in charge - and saved a lot of heartache in the process, so I will work with the organisations I inherit.

But I will also do what politicians are meant to do and that’s give people a clear and simple vision to work towards.

And here’s mine: Whole-Person Care.

A vision for a 21st century health and care service based on integration over fragmentation, collaboration over competition, public service over privatisation.

I want to explain what it means today.

To achieve it, I have to repeal the Health and Social Care Act 2012.

On a basic level, it is a shoddy, sub-optimal piece of legislation, full of contradictory instructions.

It is not worthy of the NHS and I’m not prepared to leave it saddled with it.

For all the fluff produced by ‘the Pause’, the Bill’s underlying direction remained – and that direction is a fast-track to fragmentation, competition, privatisation.

Now I know people will say – didn’t your side open the door to this?

And yes, to a degree, we did. But the Health and Social Care Act takes the doors off their hinges and the floodgates as well.

And the benefit of Opposition is that you do get a chance to stand back and re-think from first principles.

And that’s what I’ve been doing.

Politicians of all sides now have a fundamental choice to make.

Do we embrace the inexorable advance of the market into the NHS as an inevitability?

Or we can do something different – preserve a planned, national system.

I am clear that we go for the latter.

But such is the pace of change, it’s a choice that may not even be open to us at the 2020 Election – the window will have closed.

I am clear that, if we let the market genie fully out of the bottle, we will over time lose what is precious about the NHS – a service that is more than the sum of its parts, a service that’s ‘For Everyone’, as famously celebrated by Danny Boyle.

But this is not ideological comfort zone stuff, as some may argue.

It’s based on a hard-headed assessment of the future.

I am clear: there are two reasons why marketisation is the wrong answer to the challenges of 21st century care.

First, cost.

All the evidence from around the world tells us that market-based health and care systems end up costing the country more, not less than planned systems.

We spend 9.8% of GDP on health on a system that provides decent comprehensive, universal cover. The United States doesn’t do that and yet still manages to spend 17.4% of GDP on health.

And we spend significantly less than our neighbours: France spends 11.8%, Germany 11.6%.

Why?

Because that ability to plan at national level – to set what can be afforded in terms of treatment standards, staff costs, to organise how complex, expensive services should best be located - is what makes our system inherently efficient.

So when managing costs and rising demand is this century’s big challenge, how can swapping planning for the market possibly be the answer?

But there is a more fundamental human reason why markets are the wrong answer.

In the century of the ageing society, they won’t deliver what families are looking for.

They deliver fragmentation; the future demands integration.

The logical result of open competitive tendering or Any Qualified Provider is to bring an ever-increasing number of providers onto the pitch dealing with ever-smaller elements of one person’s care.

Already, families get frustrated in having to repeat the same story to every professional who comes through the door.

They get passed from pillar to post in the battle for support.

They despair that the system can’t provide a co-ordinated response to all of one person’s needs.

And those frustrations will only intensify in a world where everything is parcelled out to the lowest bidder, to competitive organisations that have no incentive to share information.

Markets in health have a large financial and human cost.

But they may also prevent other barriers to the best care.

Coming out of the Francis Report, all the emphasis rightly must be on maximum openness and transparency.

Publication of clinical and other data was a process begun under the last Government and I have been pleased to see this Government’s commitment to continue it.

But there is a real tension here.

Will organisations in a competitive market, where reputation matters, always want to share all their data?

When we have asked for details of the contracts awarded under AQP, we have been told they are ‘commercially confidential’?

That does not sit comfortably with the post-Francis world where openness must rightly trump everything else.

It seems to me that the Government has to address a contradiction here in its policy.

If it wants more non-NHS providers, then surely it must ensure that the full effect of Freedom of Information provisions need to apply to any holder of an NHS contract?

More broadly, the Government’s overall response to the Francis Report begins to reveal more about how it sees the future.

In short, it has put its faith in regulation.

Perhaps following the model in other utilities, it seems to be saying that it sees a future of autonomous providers in a competitive market balanced by tough, independent regulation.

So we have seen a flurry of announcements:

A chief inspector of hospitals.

A chief inspector of primary care.

A chief inspector of social care.

And the confusing thing is that they were not actually recommendations of the three year public inquiry they commissioned.

Labour supports Robert Francis’ recommendations and we think the Government in its response would do better to stick to them, rather than re-writing them or adopting a pick-and-mix approach.

On issues like the duty of candour, the regulation of healthcare assistants and new benchmarks on safe staffing, we stand ready to provide full support to make them an early reality.

Instead, we see an emerging narrative about heavy-handed regulation and I want to sound a note of caution.

Regulation matters, and I welcome moves to improve it, but it is at best only part of the answer.

It won’t deliver the culture change we all think is needed and we are putting our faith in the wrong place if we think regulation is the answer to all of the future challenges we face.

The risk is we find ourselves expecting too much of it.

Regulators cannot be everywhere, all the time. Patients and their families are the most powerful regulators - which is why we must ensure they have a stronger and more powerful voice in all parts of the NHS.

A Chief Inspector of Hospitals – fine man that the incoming one is - risks cementing the pre-eminence of the hospital over the system, when we all know resources must be unlocked from the acute sector and hospitals need to change.

If we focus too much on regulation, I think we are in danger missing the bigger picture.

And this brings to Labour’s emerging alternative.

I have thought long and hard about what went wrong at Stafford and there is no doubt that there were failures in the regulatory system.

But I’ve also asked myself why we hear the same recurrent story from across the system of the older people lost on the acute ward, disorientated and dehydrated.

My answer is that the problem goes far deeper and is fundamentally about demographic changes and the failure of our 20th century health and care system to anticipate them.

The ageing society is not a distant prospect but a reality on the front-line of the NHS right now.

As we all live into our 80s and 90s, our need become more complex – a blur of the physical, mental and social.

And yet, In England today, we are still trying to meet one person’s needs through three separate services based on the physical, mental and social.

If you find yourself in any part of this system, it is likely that only some of your needs are being properly met.

People with serious mental health problems who spend long periods of their life in mental health setting often have their physical needs neglected, which helps explain the shocking statistic that they are likely to die 15 years younger than everyone else.

It also explains why, because hospitals are not geared up to deal with social or mental needs, the older person can often drop like a stone in the acute hospital environment.

And the problem we’ve got now is that, if we do nothing and leave the status quo in place, this problem will only get worse and worse and our hospitals will become ever more full of desperately frail older people.

That’s because our 20th century system has no real incentive to invest in prevention.

Social care is the preventative, human side of care.

A bit of help with the task of daily living, getting up and about, means you can delay the day more expensive medical support.

But the social side of care was left out of the original NHS settlement.

And that explains why, for all the talk over many years, prevention has never been in the DNA of the NHS.

It remains a treatment service, there to pick up the pieces when people fail at home.

But the trouble is that support is increasingly being withdrawn from the home.

Council budgets are under intense pressure and their main imperative is to keep the Council Tax down.

And they now have an inadequate budget which is being stretched ever more thinly as the population ages.

The net result of all this has been huge disinvestment from social care over a long period of time and a cost-cutting contracting out culture that has seen standards fall.

I put this to you.

Will we ever get the standards of care we aspire to for our own parents, indeed anyone’s parents, from a malnourished, minimum-wage system where care is delivered in ten minutes slot with barely time to make a cup of tea let alone exchange a meaningful word?

Surely looking after someone else’s parents is the highest calling that a young person can answer rather than the lowest as we seem to be saying today?

But councils having an incentive to disinvest creates another problem – the powerful pull of funds into the acute sector.

Hospitals are still paid by how many people come through the door.

So the flow of funds is in the wrong direction.

If we do nothing, we will pay for failure on a grand scale.

The last resort of the hospital increasingly full of older people who shouldn’t really be there – bad for them, bad for the nurses who find the pressure increasingly intolerable, bad for taxpayers paying for expensive unnecessary bed days.

So we have to do something different. We must turn this system on its head.

And that we only happen when we have one service and one budget that sees the whole person, responsible for the spectrum of care from home to hospital.

I’m not talking about a little bit of integration, as someone said yesterday, but full integration of health and care.

We will continue only talking a good game about integration if we don’t crack the finances and create an incentive to provide the highest quality home-based support.

One service, one budget, one team looking after the whole person.

I see a world where the NHS takes on responsibility for co-ordinating the provision social care, possibly on a ‘year of care’ budget approach.

Every area will need an integrated care organisation – providing for the physical, mental and social from home to hospital.

I would like to see the DGH grow out of the hospital and into this role.

And that’s why the NHS Preferred Provider principle is at the heart of this approach.

That doesn’t for one second exclude a role for voluntary or private providers in a supporting capacity.

But I think we will only get the service we want if we unlock the resources and the expertise of the acute in the right way, a positive way, offering a future to grow into.

Of course, there are big implications here for hospitals and I am ready to face up to them. They will need to change.

But this approach offers a positive context in which that can happen, moving resources over time out of those general medical beds for older people and into better community provision.

In the 21st century, the home rather than the hospital needs to become the default setting for care.

An NHS in the lead on provision should be balanced by two things.

First, families with more powerful rights than they have today.

Second, by Local Government taking a lead role on commissioning through the Health & Well-being Board.

On the first, choice and control are good things – essential – and the realisation I have come to is that you can have more advanced notions of both in a more integrated system rather than a competitive system.

Sometimes the choices we offered were fairly meaningless – which provider do you want to go to for your hip operation?

Real choice is how and where do you want to be treated, for instance do you want your dialysis, your chemo or even to end your life at home?

Those choices become more deliverable by organisations that can span the spectrum of care, from home to hospital, and that’s why I would look at enshrining them in the NHS Constitution.

But we need to start talking about people not patients, thinking about a social model rather than just a medical model.

So great are the lifestyle and demographic challenges of this century that we need to change the paradigm – start commissioning good population health as opposed to narrowly commissioning health services.

So we need to make the policy link between health and housing, health and leisure, health and planning, health and worklessness, health and education – the full Marmot agenda.

People have forgotten that Nye Bevan was the Secretary of State for Health and Housing. Somewhere along the line we lost link and we need to get it back.

I hope you will feel that in here there is the beginnings of an answer to the challenges we face.

The acute hospital and the council are the twin pillars of any community in England.

But, today, those pillars are crumbling as both struggle under the weight of what is being thrown at them.

Their interests are bound up together and we need to get them in proper alignment.

Both need a future to grow into and this proposal offers that.

And to return to where I started, and people’s fears about re-organisation, I don’t see this as a big bang change but more of an evolution.

Local areas would set the own pace towards it.

And I also don’t think I telling anyone anything new or that they don’t want to do. This is a direction that many are already moving towards.

People everywhere are realising that integration is not desirable but a necessity.

What I am offering is a much quicker route to get there, in a system built to encourage it, rather that fighting the tide of fragmentation as so many are right now.

And I’m also offering a proper relationship between national and local levels.

It is the national politicians job to see out the ‘what’ – what is every citizen’s entitlement to physical, mental and social care.

It is the local job to decide the ‘how’ – how do we deliver that entitlement in this community?

Too often in Government, we tried to do both – here’s what you need to do and how you need to do it.

In future, I want to get that relationship in proper balance where entitlements is a national decision, not local at is know in social care, but where models of delivery are decided locally.

It’s big agenda but just imagine the possibilities in a fully integrated service:

One point of contact for all of your mum or dad’s or your child’s needs, because this is as applicable to the start as the end of life;

If mum or dad goes into hospital, social care support able to go with them and provide support when you’re at work.

Mental health clinicians is all settings in a century when mental health will need to move from the fringes to the centre of the service.

A national health and care service set up to deliver “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” – that 1948 WHO definition.

What better way to mark the 65th anniversary of the NHS than to set out a new vision for it in the 21st century, an NHS able to look after the whole person.

But, while it’s good to have a positive vision, I am also realistic. In an era of less, where I can’t plan on having new money, combining the £100 billion NHS budget and the £15-20 care budget in this way might be the only way to make services sustainable.

In conclusion.

While it might sound like I think I do, I can assure you I don’t yet have all the answers.

I have started my policy consultation as I want you to understand where this thinking is going, to shape it and help me build a genuine alternative.

I am sure you will disagree with things I have said.

But I want at very least to get to the next Election with a policy which you have seen develop and understand what it’s trying to achieve.

And, if I can, I want to achieve more.

I know people in the NHS have been left battered, bruised, demoralised by what’ve been happening.

I want to give them hope.

I don’t just want a policy they can accept.

My aim is to give them a policy they believe in, that is worth voting for, that is true to their belief in the values of the NHS.

Thank you for listening.