

Responsibility in healthcare: changing the culture

A 2020health discussion paper
January 2010

Emma Hill
Julia Manning

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Richard Titmuss Professor of Social Policy, London School of Economics and Political Science

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Doug Naysmith MP
Joint Chair of Parliamentary Labour Party Health Committee

“The NHS needs a cross-party consensus, based on the best evidence, and a long term plan, so we can finally give public health and prevention the space it deserves. The simple act of walking at every opportunity has as big an impact on physical and mental health as any drug yet invented, so why aren't we all doing it?”

Dr Phil Hammond
GP, writer, journalist, broadcaster, campaigner, comedian and lecturer

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About this publication

This publication was inspired by fringe events held at both the Labour and Conservative Party Conferences in Autumn 2009. We were delighted to have Niall Dickson, Chief Executive of the King's Fund; Professor Julian Le Grand of the LSE; and Stephen O'Brien MP and Doug Naysmith MP join us at their respective conferences. The sessions were superbly chaired by Dr Phil Hammond who enabled the meetings to be interactive and reminded us all to retain our sense of humour!

The speakers were asked to address the subject of 'Responsibility in healthcare: changing the culture'. Meanwhile the audience were asked to write down their thoughts in response to several questions that had been handed out at the beginning of the events. This publication is a reflection of the event, the responses received to the debate and our own recommendations for changing the culture.

We are indebted to Bayer Schering Pharma for enabling these events and this publication, and to all our sponsors for their unrestricted funding, on which we depend. As well as driving our ongoing work of involving frontline professionals in policy ideas and development, sponsorship enables us communicate with and involve officials and policy makers in the work that we do. Involvement in the work of 2020health.org is never conditional on being a sponsor.

Julia Manning, Chief Executive

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Responsibility in healthcare: changing the culture

Quotes

“Prioritising public health is key to increasing responsibility in healthcare. A focus on preventative treatments and technologies that involve patients in their own care will help individuals to take control of their health and gain a greater realisation of the consequences of their lifestyle choices. Greater access to health records will also enhance the relationship between doctors and patients and facilitate patients' growing interest in the care they receive from the NHS.”

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Disclaimer

Individuals who presented at our fringe event did so in a personal capacity and their views do not necessarily represent the corporate view of any organization. None of the speakers at the fringe events were paid and they are not responsible for the views expressed in this paper. This is solely the responsibility of the authors.

Executive summary

Historically, prevention has been the mainstay of public health. However recently the UK has witnessed a shift towards a curative attitude. 2020health want to refocus the debate on personal responsibility and control and its role in the NHS and for public health in general. Our recommendations were influenced by feedback at our conference events and discussions with front line professionals.

The justice in having a universal, free at the point of delivery healthcare system is that it ensures equity and access for all. The danger is that this deters both self-care and cautious living (risk displacement) and encourages profligacy by the public. The reality is that the NHS has not been entirely free at the point of delivery since 1951 but there has been a great reluctance to determine what 'core' NHS services should be as the debate is stifled by political fear of being seen to be 'privatising' the NHS.

Yet while we discuss as a nation the need for huge cost-reductions, we feel that the debate will lack integrity if we fail to discuss all options that will incentivise greater personal control over healthcare.

Recommendations

1. Principle that should guide decisions on which conditions can be treated by the NHS.

- > We need a public review to identify the normal human variations for which treatment should not be paid by the tax payer.

2. Personal accountability for looking after your own health.

- > A review of common, 'basic' drugs should be undertaken to see what should be removed from NHS funded prescribing.
- > A consultation should be undertaken on how to encourage the uptake of self-care using modern, mobile technology.

3. Responsibility in health promotion

- > We need to find a balance between the benefits of easily accessible information and risks of further medicalisation of daily life.

4. Personal long term health concerns

- > Health concerns are important to us all. Through our public policies we should always communicate that we value the manner of our living above the timing of our dying.

5. Encouraging a culture of responsibility in healthcare

- > Advertising the cost of healthcare e.g. A&E attendance, RRP of medicines and medical devices should be initiated.
- > The introduction of penalties for repeated avoidable trips to A&E.

Introduction

Despite the huge increase in NHS expenditure over the last ten years, there are still severe strains placed on the health service in its attempts to cope with public health issues in the UK. Many difficulties stem from unhealthy behaviours and poorly designed health incentives. The NHS constitution has endeavoured to set out "patient's rights" in line with "patient's responsibilities". However this has been polemicised as an attempt to inhibit any changes to the NHS by a new government.

It is true that the NHS belongs to us all¹, and the constitution now states that we are all responsible for it. There are still substantial challenges as to how to achieve the 'right' to access quality healthcare and how as a country we can afford to provide this. Many health professionals, public and politicians alike feel that the solution partly lies in preventative medicine and greater public awareness.

£4.2bn is spent on obesity-related issues every year, £2.7bn on illness related to alcohol abuse, up to 10% of the entire NHS budget on type 2 diabetes-related treatment and £1bn on sexually transmitted infections. Missed GP appointments alone cost in the region of £160m annually, costs which could be easily alleviated by a sense of individual and collective responsibility for our own health and for our health service. With burden on the NHS expected to increase, our health service seems stretched beyond its capacity to cope. What, then, can we do to better manage these social and economic costs?

Method

We sent the speakers at the fringe events several questions to stimulate their thinking on this subject:

- **'Free' Service:** Does the 'safety net' of universal healthcare encourage irresponsibility? How do we change the way that people view the NHS?
- **Incentives:** To what extent should healthier lifestyles be incentivised? What means are there to encourage people to stay healthy?
- **Prevention:** How do we encourage people to make healthier choices? How do we encourage young people to consider their long-term health?
- **Elective procedures:** Cosmetic surgery is paid for by the NHS in cases of 'severe stress'. What is acceptable? How far does the NHS' remit extend?
- **Access:** Has improved access had the unintended consequence of encouraging frivolous use of services? Do walk-in centres mean that self-care from a pharmacy is discouraged?
- **Family Breakdown:** The health of both adults and children suffers when families breakdown; can the British be persuaded to accept earlier intervention?
- **Diagnostic Drift:** Can we reverse the extension of conditions that were once lifestyle issues and are now labelled medical?

1. Department of Health, NHS Constitution 2009

Introduction

Each speaker was then invited to present their thoughts for up to 10 minutes on one or more of the above questions. We also devised questionnaires for the audience to respond to and collated feedback during and after the event.

The purpose of these questions was to stimulate thinking and dialogue on the subject of encouraging a “culture of responsibility”. This report has been built out of the feedback response received from the event participants. The feedback consisted of a series of brief questions, a space for comments and asked for some demographic details. We feel that that the feedback is a good indicator of individual and party opinion on the issue. This ‘thought capture’ was described by the chairman at the beginning of the session so that as ideas and questions occurred to the audience, they could record them. This material record is the basis of our report alongside the expert opinions of our panellists. The diversity of opinions reflects the diversity of the audience’s age, gender, location and political alignment.



Findings

The audience were asked 5 brief questions and, as expected, answers varied in degree and extent. Our sample consists of the answers given by 18 respondents.

When asked ‘what principle should guide decisions on which conditions can be treated by the NHS?’ Our respondents varied dramatically from extremes to a medium. Mostly it was felt that there must be a better balance between cost and need. Respondents on the whole felt that treatment on the NHS can be conditional as opposed to a blanket approach. The overarching theme was that access to NHS treatment should be conditional on an individual’s responsibility, NHS resources and benefit of the expected outcome. One participant said that the services available should balance fairness and quality with cost and efficacy. There was a general dissent to ‘elective procedures’ being available on the NHS. Another suggested a patient contract to commit them to a person to remaining in optimum health. Most participants agreed that cost should be a driving factor, only a few advocated a ‘blanket’ principle.

When asked ‘to what extent do you think that an individual is/should be accountable for looking after his or her own health?’ Nobody denied that individuals were responsible for their own health unless congenital and accidental disabilities were factored into the equation. However it was argued that in order to be responsible people needed to be fully informed and educated about how. Solutions proposed for this varied from health diaries and “sin” taxes to greater partnership with clinicians.

We also asked ‘do you feel that retailers, manufacturers, planners, etc. Have/should have a responsibility to promote public health?’ The majority of respondents felt that manufacturers and retailers certainly had a responsibility to the public. One claimed that there should be an environment of corporate social responsibility, whilst others argued that well-being can not be sacrificed for the sake of profits. In opposition a respondent argued that although companies had a responsibility to produce health products, they did not have to promote public health. Another maintained it was government responsibility, and retailers had a responsibility only insofar as not to mislead. One expressed that it was also about promoting the idea that healthy food wasn’t prohibitively expensive. Often alcohol, cigarettes, high fat and sugar content foods were used as examples. Complexity was a factor, some expressed it was government, schools and pharmacists responsibility as well to promote public health.

Our fourth question was more personal to the individual, we asked ‘in your daily life, is your long term health a major consideration for you?’ Despite some cynical responses, on the whole respondents felt that health was a major consideration in their daily lives, though pointedly warned against paranoia and when liver transplants were to be expected. Most felt a desire to maintain a healthy life for as long as possible and recognised that lifestyle and diet choices had a great role to play.

Findings

Lastly we asked ‘how would you encourage a culture of responsibility towards healthcare?’ Some respondents thought that advertising the costs of healthcare to the NHS would make people reflect more on their own health choices. Mainly education and cost efficacy were advocated as solution. Where it was felt that education from a young age, transparency of costs and possibly a minimal charge would help unnecessary spiralling costs to the NHS from, for example, missed GP appointments. Many felt that labelling and warnings were adequate, and the problem lies in reaching people who do not read these. As an extreme some respondents felt that penalties should be introduced for ‘reoffending’. Other ideas included teaching people about cooking and eating, transparency of nutritional content in restaurants and further restrictions on food advertising. All respondents agreed that this would be a cultural change.

Conclusion from Public Responses

2020health concluded that the most forward thinking, positive solution is to incentivise. This means that so called “choice architects” make more moral and objective decisions about incentivisation. Part and parcel of this is taking responsibility for the choices that you influence, for examples the “nudges” that can be made in educational initiatives.



The ‘Nudge’ agenda

The idea of incentives in healthcare is a way to influence the decisions people make, without impeding free will. This idea covers several of the initial themes discussed at the party conference event. It simply looks objectively at situations and evaluates what decisions we can make, in order to encourage others to make better decisions. This is what Richard Thaler and Cass Sunstein (2009) term ‘nudges’, and health professionals and policy makers in this context are our “choice architects”.

Thaler and Sunstein recommend an adoption of the Nudge technique, something which is rooted in human psychology and subconscious behaviour. The technique requires a good measure of behavioural analysis, something which can be directly linked to the health and lifestyle choices that people make, or more to the point, don’t realise they are making. They expose how well-designed choices can benefit more people, without much cost.

For health we need to recognise that individuals instinctively have an aversion to loss, so the losses associated with bad health choices needs to be made clear. Secondly, people are naturally subject to status quo bias. That is influenced by what they think the majority chooses. Further to this people tend towards the default option, and that the context or ‘frame’ of choice is as vitally important, sometimes more so than the choice itself. Consider that if an individual had to reflect on every singular decision they made, then our lives would be consumed with forked pathways and fraught choices². Having an intelligent default option is what makes installing computer programs relatively simple for users, and is the way that we navigate through a myriad of menu options at a restaurant.

The power behind this prompting has been utilised by marketing and advertising, Thaler and Sunstein suggest that it can also be a force for good health. Think about how by simply labelling the “healthier option” on a menu, it helps an individual sitting at a restaurant table to have greater, easily accessible information to hand with which to inform their decision. Thaler and Sunstein own examples analyse the use of nudges in the school and hospital settings, for instance to promote healthy option food choices in the school canteen and increase organ donation by presumed consent.

Case Study 1

Thaler and Sunstein also advocate using the internet as a platform for self control strategies. Stikk.com is the model they use which incentivises losing weight or exercising more by asking that weekly reports are submitted online. If a user does not obtain their goal for the week then they are penalised with a monetary fine, one that the user themselves signs up to. There is the option for this fine to be donated charitably or to a so called “anti-charity”. This resource uses support and motivating mechanisms too, such as monitoring email functions from friends and families and streams sent through to social networking sites telling of your success or failure. This sort of novel information innovation really capitalises on people’s behaviour online and demonstrates the potential transparency of the nudge agenda.

2. Thaler RH, Sunstein CR. Nudge. Penguin Books, London 2009. pp 80

The 'Nudge' agenda

People have a right to greater health options, but it needs to be fully realised that people need help with some of the more complex questions that arise. It is true that incentives that favour one type of behaviour, can improve health outcomes in real terms. It is evident that much governmental health policy would benefit from recognising that massive social changes start with a small social nudge.³



3. Thaler RH, Sunstein CR. Nudge. Penguin Books, London 2009. pp 57

Comment

Although the original Nudge idea did not pertain to health alone, since Thaler and Sunstein's book there has been some discussion about its practical bearing on healthcare in the UK. With an announcement that £15-20 billion need be saved from the NHS budget over the next 4 years, it is widely accepted that radical redesign and behaviour change will be intrinsic to any savings. Although saving money, sustaining quality and innovating healthcare is a juggling act, they need not be exclusionary principles. A recent National Endowment for Science, Technology and the Arts (NESTA) report claimed, "the NHS does not have to choose between saving money and saving lives, or between cost reduction and reform".⁴

Cuts alone will not yield this level of savings, so it is increasingly obvious that there needs to be reform of common health behaviours. This means that we need better tools to inform people and promote healthy choices, taking that vital step away from the dominant curative attitude. The realisation of the nudge technique might help so called 'choice architects' positively influence individuals to take greater responsibility for their health. This sort of choice design would also align with the person-centric model of healthcare.

In the public sector, the nudge technique is a great way of simplifying health care initiatives, and sheds light on why some public health campaigns have failed before. Health officials should be trained to think of the language they use, the choices they create and take a much more user friendly stance on their communications. This includes educational health drives, which featured prominently in the conference feedback.

Case Study 2

Many of our respondents thought that individual responsibility for health should be advocated in the education setting. This is in line with the current schools citizenship programme which includes healthy living⁵ and feedback from the Royal Society of Public Health (RSPH) who think that public health campaigns should be aimed at young people. Recently across Britain there has been a campaign accompanying the roll out of the Human Papilloma Virus vaccine (HPV) to all 12-18 year olds, called 'Taking Responsibility for your own Health'.⁶ This campaign provided teachers with resource materials to help them inform the choices of pupils. These guides provide an opportunity for young people to explore disease concepts like cause, detection and prevention. It is relatively easy to identify teachers as 'nudgers' or primary 'choice architects' although in this context, it is probably more effective (due to knowledge base) and realistic (due to demands on teacher's time) to have health professionals delivering these messages in the school setting. We should also be mindful that for children, 'choice' should not be allowed to become a burden or to be valued above truth.

4. Bunt L, Harris M. The Human Factor – discussion paper. The Lab, Nesta. 2009.
<http://www.hsj.co.uk/Journals/2/Files/2009/11/4/Lab%20-%20Health%20v8.pdf>

5. <http://www.teachernet.gov.uk/wholeschool/healthyliving/> [accessed 18.12.09]

6. Royal Society for Public Health. Taking responsibility for health. [accessed 10 Nov 2009]

<http://www.rsph.org.uk/en/policy-and-projects/projects/hpv-programme/Taking-responsibility-for-health.cfm>

Comment

Case Study 3

The introduction of front of pack ‘traffic light’ coding on food packaging combined with the percentage the products is of guideline daily amount (GDA) was first used by Asda. This sort of signposting facilitates a better interpretation of increasingly complex nutritional information. The Food Standards Agency found that the level of comprehension of these labels was generally high.⁷ However it is not a perfect solution, as products that also contain essential elements such as calcium in cheese or magnesium in dark chocolate are branded in ‘danger red’ because of their fat content. Also it might be underused by individuals who feel they can confidently recognise healthy foods, or conversely those who are not interested in healthy eating. Regardless, research shows that consumers do like this format and it is a low cost and simple method of relaying accurate information to better inform choices.

This can be signalled as a step towards greater corporate responsibility for informing consumers. Its effectiveness is a good example of co-operation between government and some food retailers.

Some retailers and manufacturers have argued that they are not responsible for the choices people make. This normalises the idea that people are completely free to choose, but the success of the marketing industry is evidence that organisations actively attempt to influence people’s choices. Companies need to take responsibility for the influence they wield, this is in line with the growing concerns about corporate responsibility. This goes hand in hand with individual choice awareness and is a potentially simple and low cost progression towards better health outcomes.

7. Malam S, Clegg S, Kirwan S, McGinival S. Comprehension and use of UK nutrition signpost labelling schemes. Food Standards Agency. May 2009. <http://www.food.gov.uk/multimedia/pdfs/pmpreport.pdf>

Recommendations

Principle that should guide decisions on which conditions can be treated by the NHS

We consider that ‘diagnostic drift’ or ‘disease mongering’ are draining the NHS of precious resources for conditions that are simple normal biological or social variations, or by portraying the presence of risk factors for disease as a disease state in itself. Examples of these include varicose veins, acne, short stature, IVF, body dysmorphia, cosmetic surgery and moderate increases in blood pressure or cholesterol. These resources should be being used to make treatments for disease more rapidly available to people who face serious illness.

We need a public review to identify the normal human variations for which treatment should not be paid for by the tax payer.

Personal accountability for looking after your own health

Accountability, responsibility, self-care or personal control – whichever way you want to phrase it – should be encouraged by the State. All new mothers from every background in the UK are provided with a ‘Red Book’ in which to keep and record their baby’s development and healthcare, so personally held records are not new. New technology developments are enabling the public much greater access and an easier way to track health information. One in five mobile phones already contain an accelerometer which means the phone has the capability to detect and measure motion. This means it could act as a pedometer. Nokia are experimenting with adding biosensors which will be capable of measuring blood oxygen, glucose, heart and breathing rates. There are already at least 376 applications (apps) for smart phones that allow clinicians- and any other purchaser - to access medical and diagnostic information on the go. And there is a free ‘drink tracker’ app to monitor your alcohol intake available on the NHS Choices website. Added to this, electronic healthcare records have been shown to enable physicians to remotely support people with chronic conditions and dramatically reduce their attendance at clinics.

The challenge is how to prevent those with chaotic lifestyles, disability or frailty from being penalised from not engaging with the technology that enables self-care, or even the present day opportunities of, for example, discussions with the pharmacist. Yet the availability of cheap ‘over the counter’ (OTC) common medicines should mean that people should not be given prescriptions for a basic formulary of common drugs such as paracetamol.

A review of common, ‘basic’ drugs should be undertaken to see what should be removed from NHS funded prescriptions.

A consultation should be undertaken on how to encourage the uptake of self-care using modern, mobile technology.

Recommendations

Responsibility in health promotion

There is a general consensus that responsibility for health promotion potentially lies with everyone from the individual ‘expert patient’ to the corporation to Government. Many food manufacturers and sellers have gone down the ‘traffic lights’ route of denoting on their food product the amount of significant content of fat, sugar or salt.

There is certainly a significant need for more public information and awareness of existing advice centres such as NHS Choices via www.nhs.uk. And information needs to be targeted intelligently – a campaign to encourage black men in south-east London to get their blood pressure checked failed because the advertisement poster had a picture of them taking their kids to the cinema. Feedback revealed this was not an activity that the majority identified with, so they dismissed the message as well. However we wouldn’t want to see saturation of daily living with messages that turn us all into permanent patients.

We need to find a balance between the benefits of easily accessible information and risks of further medicalisation of daily life.

Personal long term health concerns

Health was confirmed by our audience as a major consideration, but there was a sense that no one expected to be kept alive at all costs. Longevity is an increasing fact for many of us but it’s also one being promoted in some arenas as the Holy Grail of medical achievement. The provision of care in an ageing population should be about the preservation of dignity, pain relief, treating people with affection and respect, and supporting their independence and involvement in social activities. We consider that the End of Life Care Programme is one that facilitates this and reflects the responsibility on all of us to ensure we have a culture in which in which end of life care is not something to be feared.

Health concerns are important to us all. Through our public policies we should always communicate that we value the manner of our living above the timing of our dying.

Encouraging a culture of responsibility in healthcare

Knowing what something costs is an evidence-based way of enabling people to appreciate what they are receiving. This has been shown to be effective for clinicians in the hospital environment and those at the front line, and we believe should be extended to patients as well. This was reflected in many of the responses that we received. We think that the culture of people being deterred from seeking help because they are worried about ‘being a burden’ is fast fading. There is a much more prevalent culture of entitlement and we consider that a move to communicate the cost of care, starting in environments such as A&E would be a start in helping people to value healthcare. For ‘repeat offenders’ e.g. those requiring repeated medical attention for being drunk or high, penalties should be introduced. Electronic healthcare records will facilitate this.

Advertising the cost of healthcare e.g. A&E attendance, RRP of medicines and medical devices should be initiated.

The introduction of penalties for repeat offenders at A&E.

Appendices

Appendix A Audience Demographic

18 Total Respondents

Known age range (24 – 74)

Average (53)

Unknown (3)

Male / Female ratio 8:7

Unknown (3)

Counties

Hampshire, Yorkshire, Middlesex, London/Essex, Leicestershire, Warwickshire (2), London(3), Bristol (3), Oxfordshire

Acknowledgments

2020health would like to thank the original event Panel, who provided the basis for this report.

Chair

Dr Phil Hammond
GP, writer, journalist, broadcaster, campaigner,
comedian and lecturer

As well as being a practicing GP Phil has written for Private Eye and The Independent, featured on Radio 4's The News Quiz and The Now Show, and appeared on Have I Got News For You and Trust Me, I'm a Doctor amongst many others. Phil is also Vice-President of the Patients Association.



Speakers

Stephen O'Brien MP
(Conservative Party conference only),
Shadow Health Minister

Stephen O'Brien has been Conservative MP for Eddisbury for ten years. He currently serves as a Shadow Minister for Health, and chairs the All Party Group on Malaria. From May to December 2005, he served as the Shadow Minister for Skills. From November 2003 to 2005, was Shadow Secretary of State for Industry. Previously, he held the post of Shadow Minister for the Treasury.



Dr Doug Naysmith MP
(Labour Party conference only), Joint-Chair of the
Parliamentary Labour Party Health Committee

Dr Naysmith has been Labour MP for Bristol North West since 1997. He has a PhD in Immunology and was a Research Fellow and Lecturer in the Bristol Medical School until 1997. Doug is a member of two select committees: Health and Regulatory Reform. He takes an active interest in health issues and, as well as being Joint-Chair of the Parliamentary Labour Party Health Committee, is a member of many all party groups related to health matters.



Niall Dickson
Chief Executive, The King's Fund

Niall Dickson has been awarded a number of honorary fellowships in recognition of his work as the current chief executive of the King's Fund. He has previously been recognised with awards for journalism as editor of Therapy magazine, and for broadcasting as the BBC's Social Affairs Editor after starting as a health correspondent. In January 2010 Niall is due to take up a new post as Chief Executive of the General Medical Council.



Professor Julian Le Grand
Richard Titmuss Professor of Social
Policy, London School of Economics
and Political Science

Between 2003 to 2005 Professor Le Grand was seconded to Number 10 Downing Street as Senior Policy Adviser to the Prime Minister. He has written, co-written or edited seventeen books and over ninety articles on economics, philosophy and public policy.



Julia Manning
Founder and CEO of 2020health

Julia spent 17 years in hospital, home and high-street NHS eye-care services. She was a founder member of the British Association of Behavioural Optometrists, a visiting lecturer at City University, a visiting clinician at the Royal Free Hospital and a Director of the Institute of Optometry. She launched 2020health at the end of 2006.



About 2020health

2020health is a health and technology think tank with a vision of more people enjoying good health.

Our Mission

- We want to improve health through effective commissioning, competition and technology
- We seek a level playing field between the public and private sector as they work to improve health outcomes
- We search for ways in which the workforce can take more responsibility in local healthcare
- We examine the consequences of healthcare decisions on society, lifestyle and culture

We are ‘professional’ led, ensuring all we do has the constant input of people working for and in the public services. Our unique emphasis is on giving people who work delivering healthcare, the ‘grass-roots’, the opportunity to use their experience and expertise to direct our work.

Contact details

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