

# **Time for Health**

**New approaches to  
patient participation  
in primary healthcare**

**Value for People  
The Community Currency, Time Banking  
and Co-Production Specialists**

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## **1. Executive summary**

This paper concludes that:

- NHS staff are working hard to deliver healthcare with little organised participation of patients in their own healthcare.
- There is a need for new working relationships between primary healthcare, adult education and the voluntary and community sectors to make the links between health, learning, culture and the local environment.
- Patient participation is an emerging agenda which needs to be taken seriously and actively resourced by NHS managers.
- A relatively modest investment in supporting a time based currency to underwrite patient participation in primary healthcare could yield great benefits in terms of health outcomes and financial savings on healthcare, both for individual patients and for community health in general.

## **2. Introduction**

In surveys of public opinion the National Health Service is universally acknowledged to be a national treasure. Aneurin Bevan, its main architect, explained its chief purpose one year after the birth of the NHS: “*There has gone on in the past a vast amount of silent suffering, a vast amount of remediable pain and what a national health service does is to first of all make it articulate, and to the extent that it makes it articulate men are driven to redress it and I believe that in Great Britain we have made a great start.*” (1) It is good to remind ourselves why this great enterprise began and even so it can never be taken for granted.

This paper aims to show how a time-based community currency integrated into GP practices would increase motivation and participation of all the actors involved in primary healthcare. It first locates primary healthcare at the centre of the ‘healthcare landscape’ and seeks to show how an increase in evidence-based patient participation can lead to benefits for all of the actors. Specifically it goes on to explore the concept of a ‘time currency’ that acknowledges the participation and contribution of patients, care givers and other volunteers to the processes of growing healthy communities of healthy people. Finally it considers how a time currency system might practically be introduced into the practice of primary care.

## **3. The healthcare landscape**

Aneurin Bevan reminded us that the purpose of a national health service is to make suffering and pain ‘articulate’ so that we can ‘redress’ it. In the last fifty years health professionals have made major strides across a whole range of clinical problems, from arthritis to whooping cough, with major new techniques and technologies emerging, from high-tech scanners to epidemiological studies of whole populations and their health indicators. A whole public healthcare landscape has emerged which is populated by patients, health visitors, nurses, GPs, surgeons, clinical specialists of all kinds, managers and administrators working from GP practices, clinics and hospitals. Under the combined pressure of raised patient expectations, political pressure and new insights about the organisation of large institutions old ‘command and control’ structures are being challenged to break up and reorganise in order to produce more responsive, effective and efficient services at the local level. Such new thinking is often based on insights from the operation of ‘whole systems’ in nature and applied to complex problems created by the involvement of so many people. These approaches seek to ensure the viability of the whole system by gaining greater understanding of what works at each level of the system and enabling each part to function at its optimum level in cooperation with all the other parts. Such thinking also transcends traditional right/left, individual/collective, market/state political oppositions and the typical ‘silo’ thinking of departments to find the common ground for all of the actors.

Tredegar, the home of Aneurin Bevan, still provides a typical profile of the sort of pain and suffering from which the NHS was designed to bring relief. Heart disease, cancer, diabetes, breathing problems, mental health, back pain and arthritis all still feature large in surveys of health needs (see ‘Living in Blaenau Gwent’ – a needs assessment to inform the Health, Social Care and Well Being Strategy, p.3). Beyond these individual health problems the needs assessment also recognises related social problems such as access to transport, basic skills and jobs, which play a key role in quality of life and health.

Julian Tudor Hart, a long-serving GP who began his career at the birth of the NHS, reminds us that, after home and family, primary healthcare through the GP surgery lies at the heart of this healthcare landscape, the first port of call for any of us with health problems: *“All other levels of the NHS rest on general practice; the quality, efficiency and effectiveness of specialists are limited not only by the resources made available to them by the State, but also by the quality and completeness of GP care.”* He goes on to say, *“The central actors are the GPs; they occupy the stage, and without their consent, the play can’t proceed.”* Even this is not the whole script and later in the same book (*A New Kind of Doctor*) Tudor Hart says: *“If doctors are to retain a leading role in the future, they’ll have to earn it, and if some other kind of health worker can do better in terms of measured health outcomes good luck to them.”* (2). However, his vision of Public Health is much broader than that of the possible health interventions by either specialists or GPs, taking into account the wider factors of environment, diet, poverty and epidemiology of whole populations. Robin Stott, another long-serving hospital doctor in the NHS claims that, *“The vast majority of health professionals consider that the 80% of the activities which are undeniably important to our health are none of their concern.”* (3)

This is the cue to see a bigger picture for primary healthcare, appreciating the contribution of all the actors, including the doctors, nurses, health visitors, practice managers, receptionists and patients and, beyond this formal healthcare landscape, the contribution of community groups, the voluntary, public and private sectors to public health.

At the heart of the GP surgery is the doctor/patient consultation. This precious allocation of time (7 to 10 minutes?) depends for its effectiveness on many considerations: the experience, communication and diagnostic skills of the clinician on the one side and the self-knowledge, communication skills and health literacy of the patient on the other. The use of and results from this brief allocation of time set in motion a whole series of decisions about medical interventions, pharmaceutical prescriptions, resource and staff allocation, which determine the effectiveness of the whole NHS system.

In what ways then do we know whether this system is sustainable?

Statisticians and managers will measure and evaluate a range of data relating to the actions and decisions of the doctor and these are all crucial factors in a sustainable healthcare system but they are only one side of the coin - what of the self-knowledge, communication skills and health literacy of the patient, in short their *participation* in their healthcare? How should this be measured and evaluated? Even better, how may it be acknowledged and rewarded in order to encourage more of it? How can we know how effective this participation is and what range of participation is possible – from non-existent to total? Patient participation, if maximised, might also lead to a lessening of the burden on NHS resources: *“The Wanless Report concluded that an increase in understanding, self help and engagement by the public in public health over the next twenty years, would save the NHS £30 billion every year by the year 2022 – that is half the current annual budget of the NHS.”* (4)

#### 4. Patient participation – the challenges

*“It has become commonplace to pay lip service to the need for patient and public involvement in healthcare, but the reality doesn’t match the rhetoric at present.”*

*“Primary Care teams need to listen to and understand patients’ expectations and preferences. They must respect patients’ autonomy and acknowledge their role as decision-makers, care managers, evaluators and active citizens.” (5)*

In ‘The Autonomous Patient’, a wide ranging study of approaches to patient participation, Angela Coulter identifies a range of ways in which staff may value the roles which patients can play, with a ‘wish list’ of actions for staff under five headings:

1. Understand patients preferences and expectations
2. Patient as decision maker
3. Patient as care manager
4. Patient as evaluator
5. Patient as active citizen.

The actions she describes aim for maximum patient participation. These will be challenging for the most enlightened primary care practice to deliver and should be seen as an ideal to aim for, which can be measured in performance terms against the GP contract.

The Wanless Report looked at a future health service in 2022 and saw: *“Patients are at the heart of the health service of the future. With access to better information, they are involved fully in decisions – not just about treatment, but also about the prevention and management of illness. The principle of patient and user involvement has become ever more important and the health service has moved beyond an ‘informed consent’ to an ‘informed choice’ approach.”* As well as this, *“With support from the NHS, people increasingly take responsibility for their own health and well-being.” (6)*

Each of us may take on one or all of the above roles during our lives as patients and the more we are encouraged to grow into these roles as partners with health professionals the more sustainable healthcare will become.

A participatory primary healthcare system opens up new vistas for all participants:

- for GPs – reduced care load and more time for planning, research and prevention work
- for practice nurses – a new role as healthy living facilitator and promoter and sign-poster to other services
- for reception staff – a new role as information provider and sign-poster to other services
- for patients - better health, awards, satisfaction, social activities, new skills and inclusion in the healthy living community.

By providing high quality information to suit a range of learning styles and literacy levels, and a variety of experiential and learning opportunities, healthcare professionals can help patients to increase their self-knowledge and self-esteem and reduce their dependency on professionalised health services.

Experience with specialist self-help and support groups in areas such as mental health and the Expert Patients Programme show that patients suffering particular conditions can lend each other high levels of support and information way beyond what professional services are able to provide and these groups should continue to be supported in their valuable work. However, there is also a danger that participants in these groups can become 'ghettoised' and it is important to encourage patients to take part in both specialist support groups and other groups in the community in order to grow the wider 'healthy living community'.

Robin Stott concludes that, *"This type and degree of engagement, essential for our purpose, has itself a predictable health benefit. It is likely to create social capital through the formation of networks of people. The process itself is health-promoting."* (7) and Angela Coulter goes on to say that, *"Far from being peripheral, the development of a more active role for the patient and the citizen will be fundamental to securing the future of public healthcare. It is the only way to ensure its affordability, acceptability and sustainability over the long term."* (8)

## **5. Time currency – new motivators for participation**

The currency of participation is time. Each hour that someone spends improving their personal health literacy, taking part in mutual support groups or growing a healthier local community contributes to the 'social capital' of a healthier nation.

In the early 1980s Edgar Cahn, an eminent Washington law professor, found himself in a London hospital after a heart attack. Impressed by the care of the doctors and nurses around him, he pondered on the notion of dependency as he recovered and wondered if it was possible to devise a system which acknowledged 'reciprocity' of care between givers and receivers, so that all could feel valued for their contribution without using money as a medium. These thoughts led him to devise 'service credits', soon to be renamed Time Dollars, which would initially take off in the setting of elderly healthcare, where people could 'save' Time Dollars for each hour of care they gave and later 'buy' care for themselves. Time Dollar programmes were established all over the US and the first UK systems emerged in Gloucestershire in 1998 when Martin Simon established 'Fair Shares'. In the UK they are known as Community Time Banks and there are now around one hundred at various stages of development. The basic principles of time banking are simple: a paid Time Broker recruits participants to join a time bank with interviews, references and police checks where necessary; the Time Broker matches participants to 'assignments' with other participants; each hour of service gives a participant one time credit in their 'time bank account' which they may use to gain services for themselves. The results are greater trust amongst the active participants and an increased sense of community. Martin Simon describes the simple power of this approach: *"Time Banks offer people a safe framework for involvement and act as a letter of introduction to a network of local people they can trust."* (9)

So what motivates people to take part in a time bank?

For a housebound, elderly person it could be something as simple as finding someone to open the curtains, get some shopping or cook a meal; for others it might be access to transport, insulation materials, cheap food or vitamins, exercise equipment, leisure tokens or health classes. Each one of these beneficiaries agrees to help others in the circle in exchange. The health benefits of such increased contact with others have been shown in an experiment with time banking in the NHS at the Rushey Green GP surgery in South London between 2001 and 2004. A research project by the Socio-medical Research Group, Department of Social Psychiatry, St Thomas Hospital, funded by the King's Fund found that, *“An innovative primary care service, the development of a Time Bank based around a general practice surgery at Rushey Green was evaluated during its first years. A series of 20 early members were interviewed retrospectively, and subsequently a series of 41 later joining members were followed up prospectively for 6 months from time of joining the Time Bank..... Where members had become moderately or highly involved in the Time Bank it was possible to identify improvements in social functioning around physical symptoms. Among those with lesser involvement (the majority) there was no systematic change in physical or mental health. Despite the passage of time, most members were still anticipating – and with pleasure - greater involvement. Practice staff were by and large very positive about the aims of the Time Bank but did not in practice make regular referrals to it. Meanwhile many new members who were not registered at Rushey Green surgery applied to join the Bank (for example having seen publicity at the local library) and were accepted.”* (10)

From this modest experiment it is possible to conclude that this approach has merit.

If the currency of participation is time then attaching a time currency to participation makes sense because it makes participation visible to everyone, giving it both value and status. Participation which is valued is 'value-able' participation and even the choice of which participation to value needs to be made in a participatory way so that all of the stakeholders in health decide which activities are most valuable to healthy communities. Patients can thus play a key role in deciding which health prevention or promotion activities should be rewarded, which in itself will be rehabilitating and health promoting.

Each time credit exchanged acts as an ambassador for health. The accumulation of credits over time creates a new 'health currency' which is a 'currency with purpose', only to be 'earned' and 'spent' backing actions which lead to the goals of healthy communities. Each actor in the healthcare landscape is motivated by different goals. Each one sees a goal, becomes motivated and takes action towards that goal.

**MOTIVATIONS**  **ACTIONS**  **GOALS**

For a member of staff the primary motivator may be to manage workload. If it can be shown that a time currency increases patient participation, which in turn reduces workload then they may be willing to experiment with it. For a patient the primary motivator may be to feel better. If a patient can be convinced that a time currency offers them ways to feel better then again they may be willing to experiment with it. Thus each time credit embeds healthy goals, motivators and actions into healthy communities.

Regular feedback from users of services is critical for NHS managers to plan services effectively and it would be easy to offer awards for the time people are willing to

devote to attending patients participation groups, focus groups, citizens juries and the like.

In his review of time banking in the health sector, 'A Fair Share of Health Care', Martin Simon describes how the NHS could use such a simple system:

*"No-one speaks with more authenticity than patients and service users in defence of their services. They are the most valuable resource the NHS has and so when they contribute their time and wisdom it is both sensible and just to pay them back in Time Credits for the 'work' they are doing for the NHS."*

The implications of this for the relationship between staff and patients are spelled out:

*"There is immense scope for the general public to connect once again with the NHS. Everyone uses its services at some time and surveys repeatedly show that at a local level people are happy with the quality of service they receive. Patients and their families, friends, colleagues and neighbours are all touched by the NHS at some point in their lives and every type of skill and ability could be available through a Time Bank to complement the more specialised expertise of the staff."*

*"Everyone contributes skills that they enjoy doing for others when they want to do them and in exchange gains access to a range of skills on offer from others should they ever be needed. In the process a 'culture of co-sufficiency' develops. Some of the GPs we spoke to made it clear that many of their colleagues might resist a co-sufficiency approach and maintain a heroic stance of self-sufficiency toward their ever increasing workload. Yet a small but profound shift in their attitude and an appreciation of the power of co-sufficiency could enlist for them a vast team of co-workers." (11)*

There are already encouraging signs of a change of attitude amongst GPs in Wales who, for instance, are leading on the idea of an official NHS pilot on the role of complementary medicine alongside GP practice.

## **6. Implementation strategy**

Value for People exists to promote new approaches to the participation of local people in community activities by supporting the development of time based local currencies.

We believe that the only way in which the NHS will create a viable future for itself is by the engagement of the potential of patients as full partners in the process of healthcare. We assume that a system based on maximum patient participation will automatically be based on disease prevention and health promotion (wellness) at least as much as the management of sickness. This will involve new ways of teaching and learning about health, imaginative health information provision, a wider view of the determinants of health which takes in the local environment, nutrition, exercise, leisure and the arts and more open and inclusive ways of managing the relationships between all the actors in healthcare.

We recommend the following five steps towards implementation of a time currency to underwrite healthy communities:

### **Step One: Identify Key Partners**

As this way of working is new it is important for a Local Health Board to identify GP surgeries which may be willing to pilot time accreditation of patient participation as outlined in the following steps.

### **Step Two: Health Audit**

In order to address and build-up a picture of specific health needs of a community a health audit will be undertaken by key staff and volunteers:

- 1) A breakdown of the GPs caseload will highlight and provide a snapshot of:
  - a) Specific health problems within the community based on analysis of caseload into a league table of health problems.
  - b) The number of repeat prescriptions and patient visits to the surgery over a 12 month period.
- 2) Itemise existing patient support groups and complementary health practitioners in the area working from a GP health centre or working in partnership with the GP addressing specific health concerns and their impact on reducing repeat visits to the GP.
- 3) Identify current health related activities taking place in the voluntary and community sectors such as volunteering opportunities, environmental improvements, courses, information events etc.
- 4) Map all educational activities related to health and social care and citizenship in primary, secondary and adult education.

### **Step Three: Design Health Education Programmes**

Identify what healthy living programmes you wish to build over the next 12 months.

In response to the health audit, health information and education programmes are targeted at specific health concerns and gaps highlighted by the audit. Collective health education programmes are constructed, including the development of specialised health support groups (such as the Expert Patients Programme) to complement and support the work of GPs in diagnosis and treatment.

#### **Example 1: Condition - Mild Depression**

Facilitate a 'Feeling Good Course'

**Content of the Course:** Training (for example, Massage, Aromatherapy), Trips, First Aid and Food Hygiene.

#### **Example 2: Condition - Asthma**

Facilitate a 'Mutual Support Group'

**Focus of the Group:** Learning together about asthma, complementary therapies and mutual support.

**Example 3: All conditions**

Organise an Information Prescription Service

Facilitators: GPs, reception staff, nurses, local pharmacy, Volunteering sector, education providers, library.

**Example 4:** Facilitate courses for new parents and grandparents.

**Step Four: Referrals**

GPs and Social Workers refer patients to existing groups or new programmes and explain that they will be accredited for the time spent on improving their health.

Each person that joins any healthy living programme becomes a member of the ‘Community Health Network’ with their own personal health account. For each hour that a person participates in any of the following activities they receive one ‘healthy living credit’:

- attendance at Patients Participation group (eg Friends of the Surgery)
- participation in specialist support groups (eg Expert Patients Programme)
- teaching, mentoring or giving information to other patients about health.

At this point a Healthy Living Broker may be appointed to coordinate patient participation in these programmes.

**Step Five: Awards Menu**

‘Healthy living credits’ may be saved and redeemed for ‘healthy living awards’.

In consultation with the participants a healthy living awards menu is drawn up.

Examples of awards may include – Health books, group trips, respite holidays/trips, gardening materials, entrance to health classes for example Pilates in local leisure centre.

**Benefits**

- Doctors, patients, community groups and other health professionals are brought together as ‘co-producers’ of health
- Increase in community knowledge about principles of healthy living
- Health is embedded in the wider spheres of community, learning and environment by making direct links between them.

*“Doctors working alone cannot cure isolation and unhappiness. By mobilising their patients they could gain access to an enormous range of people, skills and resources. They already have contact with several thousand people in their local area. They often have a good understanding of their patients’ needs and some knowledge of the skills and talents that are available. Time Banks in GPs surgeries are a success story waiting to happen.” (12)*

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