

Doing more with less **British healthcare to 2013**

A report from the Economist Intelligence Unit
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Preface

Doing more with less: Britain's healthcare funding challenges is an Economist Intelligence Unit briefing paper sponsored by BMI Healthcare. Andrea Chipman was the author of the report and Iain Scott was the editor. The findings and views expressed do not necessarily reflect those of the sponsor.

This paper took as a starting-point the 2002 and 2004 government-commissioned reports on the National Health Service by Sir Derek Wanless. Recent research by The King's Fund, the Social Market Foundation and the National Health Service's own institutions provided additional material for the report, along with separate Economist Intelligence Unit research. The author also conducted in-depth interviews with:

- John Appleby, chief economist at The King's Fund
- Kevin Barron MP, head of the Health Select Committee in the House of Commons
- Professor Ian Gilmore, president of the Royal College of Physicians
- Professor Alan Maynard, an economist at the York Health Policy Group at York University and chairman of York NHS Trust
- Professor Allyson Pollock, director of the Centre for International Public Health Policy at the University of Edinburgh
- Claire Rayner, president of the Patients' Association
- David Stout, director of the Primary Care Trust Network at the NHS Confederation
- Jon Sussex, deputy director of the Office of Health Economics
- David Worskett, director of the NHS Partners' Network at the NHS Confederation

Our thanks are due to all who contributed to the report for their time and insight.



Introduction

It might be said of British governments that if they didn't inherit a National Health Service (NHS) that is free at the point of delivery, they wouldn't choose to create one. Such is the difficulty of satisfying public demand for quality healthcare services at a manageable cost. Never in the 61-year history of the NHS has solving this quandary been as challenging as it will prove to be over the coming years.

The difficulties will be as much political as administrative and economic. An Economist Intelligence Unit survey conducted in July 2009 found that less than one-third of Britons feel that the government has the right approach to healthcare. Whichever party takes power after the coming general election will find that the public, which has come to expect high standards of care, will not necessarily be sympathetic to pleas that there is less money in the coffers to pay for it. Policymakers will be required to walk a tightrope between a need for cost saving, on the one hand, and the political necessity of populist initiatives to expand or improve services, on the other.

For example, central to balancing both interests will be a reform of the way in which the NHS pays for medicines. The current system, which formally precludes subsidised patient access under the NHS to drugs that are not deemed cost-effective, has become a rod with which to beat the government and is deeply unpopular. The opposition Conservative Party has committed to making all "clinically effective" drugs available to patients under the NHS. To do so in a time of budget cuts will require the introduction of drug price regulation, but most importantly it would presumably stem the negative headlines about rationing of access to the latest medicines. Such a move may offer an easy way to gain political points. But it will do little to address underlying problems, given that the drug budget is only slightly over 10% of the total NHS budget.

But governments will find that the larger, more important reforms of the British healthcare system do not come with the built-in incentive of a popularity boost. Policymakers will need imagination and conviction properly to grasp the opportunity for healthcare reform afforded by the tumultuous economic and fiscal conditions.

Fears over the implications of the country's unprecedented levels of debt are now so great that opinion polls currently suggest that the public is in favour of spending cuts being applied to various government services. It remains to be seen, however, whether Britons will stomach cuts to healthcare, particularly if they are worried that standards of care will slip. But they appear to be bracing for a period of austerity, talked up by all the main political parties, in which difficulties in maintaining standards can at least be placed into a broader context. In his pre-budget speech in December 2009, Alistair Darling, the chancellor, vowed to protect hospital budgets for at least two years from 2011, with minimal real increases in spending on frontline NHS services, while reducing the budgets in other Whitehall departments by more than £36bn over three years. At the same time, he said he would cap pay rises for all public sector workers at 1% for at least two years from 2011 and cap public sector pensions by 2012.

This should alleviate some of the political pressure. It should also create an environment ripe for the



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difficult decision-making necessary to implement substantive reform. It must be hoped that the next government, whether Conservative or Labour, will be sufficiently bold to seize this opportunity.

The Conservatives' agenda claims that efficiency—a frequently heard but somewhat vague term when used in reference to healthcare—will be improved by making each treatment centre stand by the results of its services. This, it is argued, will foster competition and raise standards by allowing patients to select the centre with the best track record for different procedures. Allow funding flows to follow these results, and both quality and efficiency should improve.

But the question of how the results can be quantified remains a complex one. The development of patient-reported outcome measures (PROMs), together with a growing acceptance that health outcomes should determine the allocation of resources, represents a step forward for British healthcare. Nonetheless, the concept of payment-for-performance is still in its infancy, and will require even greater attention in the next five years.

Citizens and healthcare professionals fear that as long as politicians are focused on the notion of efficiency, their first response will be to cut costs. Reformers would do well to seek ways to reduce the length of in-patient stays, and provide a wide range of NHS services in lower-cost community facilities. But reforms are just as likely to translate into salary cuts, as the pre-budget report suggests, and the cancellation of plans to renovate or expand facilities. The next government will be at pains to avoid making cuts that affect service delivery—which is far more electorally damaging—but it is probable that the NHS's hard-fought battle to reduce waiting times, for example, will once again become harder to win.

On the face of it, the public sector funding crunch also provides an opportunity for expanded private sector involvement in NHS service delivery. Any British government might well wish that it didn't have

Regional differences

In order to chart the likely impact of a public spending squeeze in the rest of the United Kingdom, it is necessary to bear in mind some regional variations. Fiscal policy is set from Westminster, meaning that the tighter funding environment will have an impact on all of the countries within the UK, but Scotland, Wales and Northern Ireland have taken different paths from England in setting health policy that will affect their room for manoeuvre in a financial crisis. In contrast to England, with its internal health market and significant role for the private sector, the devolved Scottish and Welsh governments have eliminated the purchaser/provider split and maintained more centralised control of health policy. Both countries have also largely rejected the introduction of market forces into their healthcare systems. In Northern Ireland, although the split still exists in effect, there is a single national commissioning body that works with providers in different regions, which has limited competition.

In addition, neither Scotland, Wales nor Northern Ireland has implemented policies such as patient choice, payment by results (in which commissioners purchase care from providers according to a fixed-price tariff) and patient-reported outcome measures (PROMs), which gives them more freedom to respond to price pressures in a funding squeeze, according to Jon Sussex, deputy director of the Office of Health Economics, a think-tank. This freedom effectively makes the Scottish, Welsh and Northern Irish healthcare systems less transparent, which could give them more flexibility to adjust to a harsher funding climate while at the same time forestalling the public and political pressure to which English health reform efforts are more sensitive, Mr Sussex adds. Scotland has a number of unique advantages, including a more general health budget than that of its neighbours (giving it an additional cushion when times get hard) and the ability to increase income tax within Scotland to meet rising demands (although this right has not yet been exercised). Mr Sussex nevertheless points out that England retains at least one advantage over the other three: after nearly a decade of investment in capacity, England has the nation's lowest waiting times for treatment.



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the burden of providing high-quality free healthcare to its entire population, but after 60 years, the NHS is itself a source of state legitimacy. Whichever party wins power after the next election, it is fair to assume that NHS treatment will remain free at the point of delivery. Public regard for the concept is such that David Cameron is anxious to make clear that the Conservatives, if elected, would enshrine the basic tenets of the NHS in a formal, statutory constitution.

This report looks at what may be in store for British healthcare over the next five years. The issues it examines will be a problem for whichever government takes power after 2010, but it is fair to assume that until 2013 reform will be gradual, rather than systemic. The NHS will continue to dominate delivery of care, while the private sector will enjoy a limited but growing role in delivering outsourced treatment to the NHS. Recent innovations such as PROMs will help the NHS to focus on outcomes, rather than performance targets.

But in tough economic times, efficiencies will be demanded of healthcare, and if efficiency gains prove elusive through incremental initiatives, larger-scale reforms will be proposed, which will involve all stakeholders—public and private providers, policymakers and citizens. Opponents of private sector involvement in Britain's healthcare industry often point to the US, where quality care is unaffordable to many citizens. But they are taking an extreme view. It is beyond the scope of this report, but not inconceivable, that in years to come the British public will be asked to consider accepting a healthcare system such as that in the Netherlands, where basic care is paid for by obligatory contributions to private health insurance.



Key points

- The Wanless reviews led to a massive funding injection for British healthcare
- Outcomes of the funding have not been tracked effectively
- Recent incentives such as PROMs are beginning to address the gap between funding and outcomes

The Wanless legacy

The dilemmas facing healthcare in Britain follow two decades of rapid change. In 1990, the Conservative government under the then prime minister, Margaret Thatcher, introduced an internal market within the NHS, with the creation of a split between purchasers of health service (nominally general practice/GP surgeries through local health authorities) and providers, dominated by the hospital sector. Later, the Labour government of Tony Blair grouped GP surgeries under primary care trusts (PCTs) overseen by strategic health authorities, with one key innovation—large inflows of money. Although the increase in investment started within three years of Labour's ascension to power, the bulk of the funding injection has come during the past seven years.

Much of that injection was in response to a major review of the NHS by Sir Derek Wanless, a former head of NatWest Bank. The 2002 Wanless report, *Securing our Future Health: Taking a Long-Term View*, sought to examine the main factors required to deliver a high-quality health service through to 2022. The report noted the importance of integrating health and social care, and also the value of health promotion and disease prevention. It envisioned three potential scenarios, with accompanying cost estimates, for delivering on these aims. It maintained that new spending must be accompanied by reforms addressing poor capacity and poor access to quality services. A follow-up report two years later looked at the specific challenges facing the public health sector, with a particular focus on the cost-effectiveness of convincing citizens to adopt healthier lifestyles.¹ A final review, conducted in conjunction with the King's Fund, a think-tank, in 2007, evaluated the government's performance in fulfilling the funding recommendations of the original Wanless review.²

The first Wanless report envisioned three scenarios for the future of British healthcare. Under "Fully Engaged", the most positive, there would be high levels of public engagement in relation to health, with life expectancy increases above current forecasts and high rates of technology use in disease prevention. The middle scenario, "Solid Progress", would involve a public that was more engaged in relation to its health, with higher life expectancies and health status, confidence in the primary care system and high rates of technology use in the service. Finally, the "Slow Uptake" scenario envisioned little change in levels of public engagement, with the smallest rise in life expectancy and a constant or deteriorating health status of the population, accompanied by low rates of technology use and productivity in the health sector. The 2007 King's Fund review determined that the population and,

¹ *Securing Good Health for the Whole Population*, Department of Health, 2004.

² *Our Future Health Secured? A Review of NHS Funding and Performance*, The King's Fund, 2007.



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Healthcare: key indicators (UK)

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Life expectancy, average (years)	78.4	78.5	78.7	78.8	79	79.2	79.3	79.4	79.6	79.7
Healthcare spending (£bn)	107.8	118	128.7	136.1	141.5	145.4	147.7	149	151.5	153.7
Healthcare spending (% of GDP)	8.6	8.9	9.2	9.4	10.1	10.3	10.1	9.8	9.6	9.4
Healthcare spending (US\$ per head)	3,258	3,589	4,225	4,107	3,585	3,657	3,724	3,923	4,090	4,185
Doctors (per 1,000 people)	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.1	2.1	2.1
Hospital beds (per 1,000 people)	3.7	3.6	3.7	3.8	3.7	3.6	3.5	3.4	3.3	3.2

Source: Economist Intelligence Unit, November 2009.

correspondingly, the health system, was on a path between the middle and more pessimistic scenarios laid out in the 2002 report.

Although the health system appears in better shape than it did a decade ago, economists and managers say it has failed to fulfil other key recommendations of the Wanless review, including the implementation of reforms that would improve quality and productivity. In addition, they note, there has been little evidence that the UK public is racing to adopt the healthier lifestyle options as described by Wanless.

Total healthcare spending in the UK reached £136bn in 2008, compared with £60bn a decade earlier, with the share of GDP going to health rising to 9.4% from 6.9% in 1998, putting the UK roughly on par with the European Union average.

At the same time, the 2007 Wanless/King's Fund report pointed out that 43% of the funding increase since 2002 had gone to boosting clinical salaries and staffing—but the NHS had still not succeeded in identifying the main factors governing health outcomes. "We can see changes in health outcomes, but it's hard to attribute them in any accurate or detailed way to what we do in healthcare," says John Appleby, the chief economist at The King's Fund.

Mr Appleby concedes, however, that the NHS has taken the first step towards filling this gap. In April 2009, it began to pilot patient-reported outcome measures (PROMs), in which patients report their views about their health-related quality of life before and after treatment. The pilot surveys were introduced in selected surgical specialities, including hip and knee replacements, hernia and varicose vein operations. The Department of Health estimated that it could generate up to 250,000 reports over a three-year period.



Key points

- The NHS faces a slowdown in funding from 2011/12, exacerbated by the recession
- An ageing population is highlighting gaps in the UK's long-term care provision
- Rising costs from chronic conditions and new technology are putting the NHS under strain

The approaching storm

Pressures on the British healthcare system are likely to begin growing as soon as the next comprehensive spending review, which begins in 2011/12. After a decade of reasonably flush times for the NHS, the forecast looks at the very least gloomy, with public spending across the board likely to be curtailed by crippling government debt over the next five years, according to clinicians and analysts.

Exacerbating that problem are demographic realities. The Economist Intelligence Unit predicts that demand for healthcare services is expected to rise at a faster pace than GDP in the next five years, driven by an expanding, ageing and increasingly well-informed population, a rise in benefit levels provided by payers, advances in medicine and the steady rise in the incidence of chronic disease, particularly obesity-related illness.³

A June 2009 paper by the NHS Confederation, the membership body for the institutions making up the National Health Service, predicted that the NHS would face a "very severe contraction in its finance with an £8bn-£10bn real terms cut likely in the three years from 2011."⁴ The King's Fund, in a July report, meanwhile, discussed three potential scenarios for funding of the English NHS from 2011/12 to 2016/17: a "tepid" outlook, with annual real increases of 2% for the first three years and 3% for the final three years; a "cold" outlook of zero real change in funding; and an "arctic" scenario that foresees annual real reductions of 2% for the first three years, falling to 1% for the final three years.⁵

Politicians have been more cautious in discussing potential future constraints on the health service, although with a general election due in May 2010, they are increasingly called upon to divulge their healthcare policies in more detail. The Conservatives, for example, have pledged to cut one-third off the NHS's administrative costs—£1.5bn—by the end of their fourth year in government. Mr Cameron has pledged that "frontline services" will be protected from the razor, at the expense of the NHS bureaucracy.

Meanwhile, Kevin Barron, the Labour MP for Rother Valley, who also heads the Health Select Committee in the House of Commons, is dismissive of the more dire warnings. "The NHS is treasured and is politically secure, in my view," he says. "There is no political party that is likely to get into office that I believe would advocate cutbacks on the scale that the sirens have been suggesting." A 2009 study by McKinsey, the consultancy, which suggested that the NHS could shave up to 14% from its budget by cutting 10% of its staff, was quickly shelved by politicians and health bureaucrats.

³ *United Kingdom: Healthcare and Pharmaceuticals Report*, Economist Intelligence Unit, June 5th 2009.

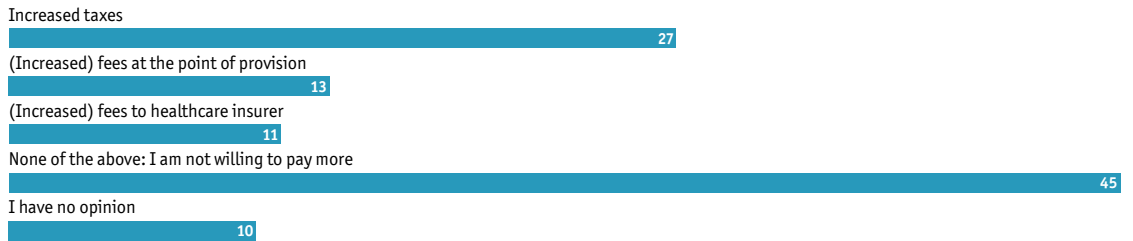
⁴ *Dealing with the Downturn*, NHS Confederation, June 2009.

⁵ *How cold will it be? Prospects for NHS funding: 2011-2017*, The King's Fund, July 2009.



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In which ways would you be most willing to pay (more) for an improved healthcare service?
(% respondents)



Source: Economist Intelligence Unit, July 2009.

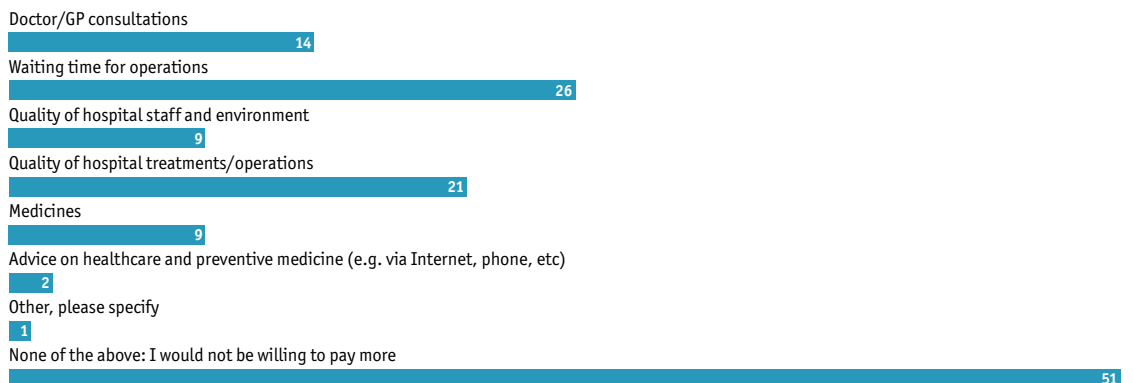
Despite the reassurances, there are signs that the public is beginning to feel anxious. A poll conducted by the British Medical Association in June 2009 found that more than three-quarters of respondents believe cuts should be made in other government departments to protect NHS funding, while 40% believe taxes should be increased to maintain the growth in funding.⁶ An Economist Intelligence Unit survey, conducted in July, found that although 45% of respondents would not be willing to pay anything extra to receive improved healthcare services, more than one-quarter would tolerate higher taxes to achieve the result. The survey also found that only 13% would be happy to pay fees at the point of provision, and 11% to an insurer, to get better healthcare.⁷

The same survey also asked citizens which aspects of their healthcare they would pay for, or pay extra, to get a better service. While more than one-quarter of respondents said they would pay for a shorter waiting time, and 21% said they would pay for better-quality hospital treatment or operations, more than one-half said that they would not pay any more.

Findings such as these illustrate the dilemma facing policymakers. While Britain's health system is likely to remain better protected than other public services, it will nonetheless face hard choices in the near term.

First and foremost among these is to shoulder the demands of an ageing population which is already putting pressure on both hospitals and primary care, and which will require escalating expenditure on long-term care.

Which of the following would you be willing to pay (more) for, in order to receive a faster and/or higher quality of service?
(% respondents)



Source: Economist Intelligence Unit, July 2009.

⁶ "BMA poll reveals the public's fear for future of the NHS," British Medical Association press release, June 26th 2009.

⁷ *Health reform: The debate goes public*, Economist Intelligence Unit, October 2009.



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NHS hospitals have long struggled with the problem of “bed blockers”—usually elderly patients who are well enough to be discharged but who are unable to care for themselves and lack a suitable place to go. Over the past few decades, the long-term care sector has been one of the biggest growth areas for the private sector. The Economist Intelligence Unit estimates that 60% of residential care home places will be private by 2013, and that the proportion of homes run by local government staff will fall to just 15% by then.

As the NHS has increasingly withdrawn from the sector, and care home residents are footing an increasing portion of their own bills, public concerns have mounted, exacerbated by the pensions crisis. In July 2009, the government of Gordon Brown issued a green paper on long-term care,⁸ outlining a wide range of funding options under consideration, including combinations of state contributions and top-up insurance. A final solution is likely to be far from quick, however.

“The green paper out right now on social care says that, regardless of the financial situation we are in, the existing social care system isn’t affordable or acceptable,” says David Stout, director of the Primary Care Trust Network at the NHS Confederation. “You can’t isolate the health service from social care. You can’t have the NHS flourishing and social care struggling.”

Meanwhile, the growing percentage of the UK population with chronic conditions such as cardiovascular disease, diabetes, obesity and related health problems, is already placing a similar burden on the health service. These conditions account for some 80% of all health expenditure in the UK; with money in shorter supply in the years to come, there is likely to be an even greater emphasis on preventive care, and on trying to treat more patients for longer outside of hospital.

An Economist Intelligence Unit survey conducted in early 2009 found that British healthcare professionals see patient-centred care (in which patients have more involvement in self-management of their health, in deciding on and administering their own treatments, and in which patient information and care are more integrated) as playing a vital role in the future, both as a way to get patients to take more responsibility for their own health, and relieve pressure on budgets.⁹ But analysts are sceptical, pointing to the conclusions of the 2007 King’s Fund report and other reviews which show that preventive health initiatives aimed at getting people to diet, exercise and live healthier lives have mixed results, at best.

Finally, these demographic trends are compounded by the prospective financial burdens from new medical treatments, technologies and innovations. The UK already has an agency—the National Institute for Health and Clinical Excellence (NICE)—that offers cost-benefit analyses of new medical technologies and provides guidance to the Department of Health and local PCTs, but the way in which it decides on which technologies and treatments should be made available to the NHS has proved controversial (see Chapter 3).

How to divide scarce financial resources among a host of potentially state-of-the-art but costly medical technologies will be one of the issues confronting health service managers in the next five years. Indeed, in March 2009 the Department of Health changed its guidance to local health regions in England, directing them to allow NHS patients to pay privately for treatments not provided by their local health authorities without losing NHS coverage for their conditions in the future, as had previously been the case.

⁸ *Shaping the Future of Care Together*, Department of Health, July 14th, 2009.

⁹ *Fixing Healthcare: The Professionals’ Perspective*, Economist Intelligence Unit, February 2009.



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David Worskett, director of the NHS Partners' Network at the NHS Confederation—which represents commercial and non-profit healthcare providers involved with NHS care—believes it is difficult to predict how the NHS might respond to tough economic times. Parts of the NHS, he notes, will take a traditional road, slicing budgets and hoping that it can continue to offer the same standards with less money. "Some will start on that route and find quite quickly that they aren't achieving big enough savings, and are dropping on quality and patient satisfaction and waiting times," he says. At that point, they are likely to shift course, and look at ways of innovating and redesigning services and products—as a private corporation would do, according to Mr Worskett.



Key points

- Future reforms will emphasise cultural rather than structural change
- Efforts to improve the quality of healthcare delivery will take centre stage
- Attempts to eliminate variations in services must be reconciled with a further decentralisation in decision-making

It's about outcomes

After two decades of structural reforms and one of more generous budgets, the verdict on outcomes remains mixed. Analysts and clinicians say that the way forward for British healthcare depends not so much on a new reordering of the system as on standardising treatment across regions and smoothing the flow of care between primary and secondary sectors. Scarcer resources provide a unique opportunity to concentrate minds, according to several of those interviewed for this report.

Since the introduction of the internal market for healthcare in 1990 and the division of the NHS into purchasers (health authorities and some GPs) and providers (hospitals, community health services and GPs), successive governments have tried to put their own imprint on the architecture of the health system. Structural innovations have included allowing some large GP practices to hold and control their own funds, the establishment of foundation trust hospitals with greater financial and political autonomy, and the introduction and expansion of the role of private healthcare providers across the secondary and, increasingly, the primary healthcare sector.

But constant reorganisation has left NHS staff and managers weary and, at times, demoralised, says Mr Appleby of The King's Fund, who adds that the service is consequently likely to resist further major changes. In a report, the Social Market Foundation concurs, adding: "Structural upheaval has characterised healthcare reform in England over the last ten years and more of the same is not the way to a stable, efficient and quality service."¹⁰

Moreover, according to those interviewed for this report, there is recognition that neither the structural reorganisation of the past two decades nor the influx of new funding under Labour has had a measurable impact on the quality or efficiency of the health service.

It is the intangible concept of quality that is likely to be at the crux of policy changes over the next five years, and was the subject of a June 2008 report to the government by Lord Darzi, the former undersecretary of state for health. The Darzi review concluded that the variation in the quality of healthcare across the NHS was the key problem facing the service.¹¹ While the review outlined the government's focus on preventive care, it also noted that quality improvements over the past decade have been largely focused on waiting times, staffing levels and physical infrastructure and promised to "raise standards".

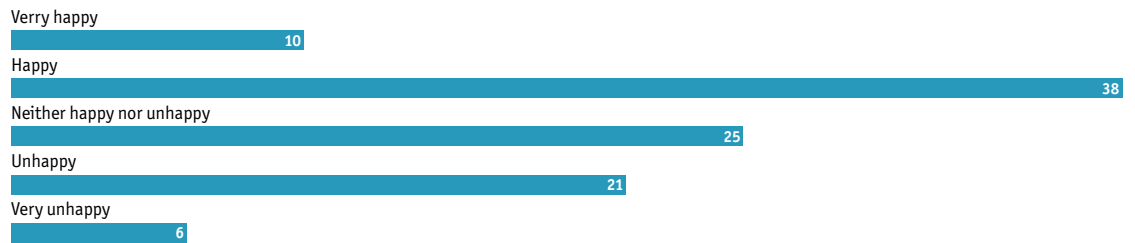
¹⁰ *From Feast to Famine: Reforming the NHS for an age of austerity*, Social Market Foundation, July 2009.

¹¹ Lord Darzi noted that "for the NHS to be sustainable in the 21st century, it needs to focus on improving health as well as treating sickness." *High Quality Care For All: NHS Next Stage Review Final Report*, Department of Health, June 2009.



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Thinking about your own job, how would you rate your level of satisfaction with regards to overall job satisfaction?
(% respondents)



Source: Economist Intelligence Unit, February 2009.

Most of those interviewed for this report agree that the service needs to shift focus “back to basics” and away from performance targets. “The real thing that people need is time, care and attention,” says Professor Allyson Pollock, director of the Centre for Public Health Policy at the University of Edinburgh.

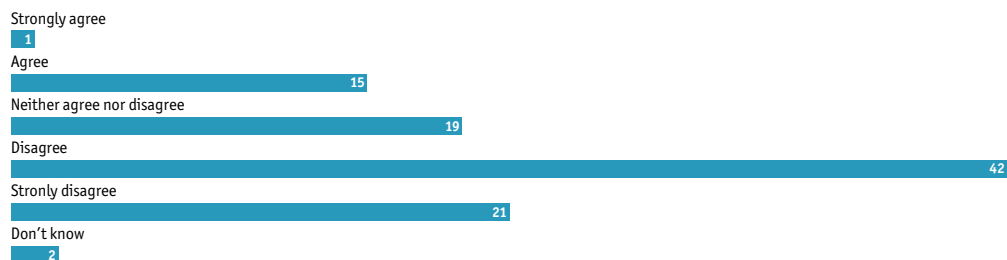
An initial priority will involve encouraging co-operation between the primary and secondary sectors in an effort to improve quality and reduce expenditure on more costly hospital care. “I think it’s possible that if there is a move towards more care in the community, hospital doctors will work in different ways,” says Professor Ian Gilmore, president of the Royal College of Physicians. “There may be a concentration of highly specialised centres; there may be specialists working across the primary care divide. We’re already seeing specialists in geriatric care being employed by primary care trusts rather than in secondary care.”

But getting medical staff on board to accept and help the reform process will also be crucial, says Mr Stout of the NHS Confederation: “If we don’t, we will have a really big challenge in convincing the public that we are doing the right thing.” His concerns appear well-founded—an Economist Intelligence Unit poll in early 2009 found that the majority of healthcare professionals, including physicians, nurses and specialists, admit to being less satisfied in their jobs than they were two years ago, and less confident that the healthcare system can cope with increased demands.¹²

In addition, there will be increasing pressure on government and local health managers to resolve the conflict between political support for local health decision-making on the one hand, and demands in Westminster for greater standardisation of the procedures and care offered by local health services, on the other. The media has been quick to pounce on inconsistencies in how individual primary care

¹² *Fixing Healthcare: The Professionals’ Perspective*, Economist Intelligence Unit, February 2009.

Please indicate to what extent you agree or disagree with the following statement: My country’s healthcare system has the capacity to cope with rapidly growing demand for care.
(% respondents)



Source: Economist Intelligence Unit, February 2009.



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trusts follow guidance from head office, two recent examples being fertility treatment and respite help for care providers.

The Social Market Foundation advocates devolving power away from central government to local commissioners—PCTs or GPs—who contract with health providers for services. It argues that by giving local commissioners greater autonomy, they can make the best decisions on how to allocate resources according to local needs. It also acknowledges that this will require a careful balancing act on the part of policymakers: “Political courage will be needed if a move away from the persistent idea that the NHS is the same everywhere is to be achieved. But the benefits of local choice must supersede concerns about postcode lotteries.”¹³

Commissioning of healthcare is, for the most part, currently the responsibility of PCTs. Interviewees for this report argue that commissioning will be inextricably linked to improving the quality of healthcare in the future. “We need to look at what PCTs commission—it’s not always what they are

¹³ *From Feast to Famine: Reforming the NHS for an age of austerity*, Social Market Foundation, July 2009.

NICE way to keep costs down

Efforts to reconcile healthcare quality with cost control within the National Health Service (NHS) in the future will depend in part on the National Institute for Health and Clinical Excellence (NICE). Established in 1999, NICE’s role is to provide independent national guidance about health promotion and disease prevention for England and Wales. The agency’s remit covers public health, clinical guidelines and technology appraisals.

It is in the area of technology appraisals, which encompass recommendations on new medical treatments, that its role has been most controversial. Using a guideline that limits affordability for NHS drugs to £30,000 per patient per quality-adjusted year of life, NICE has drawn fire from patients’ groups and some physicians for initially declining to recommend some of the newest treatments, such as Tarceva, a lung cancer drug, and advising restricted use of others, such as Aricept for Alzheimer’s, after determining that they did not provide sufficiently positive outcomes to justify the high cost per patient.

Meanwhile, some Strategic Health Authorities have balked at the high cost of some treatments that have been recommended by NICE, leading to a much-lamented “postcode lottery” in which patients’ access to medicines depends on where they live. “We all know that if the public gets behind a medicine, politicians in England find it very hard to say no when they know people in France and Germany or Scotland are getting it,” says Jon Sussex, deputy director of the Office of Health Economics.

Alan Maynard, an economist at the York Health Policy Group in the Department of Health Studies of the University of York, and

chairman of York NHS Trust, has criticised the agency for focusing on expensive new treatments rather than evaluating the cost-effectiveness of all treatments the healthcare system is using. “The problem with NICE advice is that it squeezes out other activities,” he says. “Much of the stuff coming out of NICE is only marginally cost-effective. They are looking only at new technology, and it’s a very narrow range of very expensive drugs.”

A NICE spokeswoman pointed out that the institute can only evaluate topics referred to it by the Department of Health; NICE’s clinical guidelines cover a much wider range of treatments, she adds.

Despite its perceived faults, the NICE model for evaluating the cost-effectiveness of medical treatments has earned close attention from governments abroad—even the US, which is in the midst of a political battle over healthcare reform that will require the government to lower expenditure significantly. If the NICE model catches on in the US, where patients currently pay substantially more for drug treatments than in Europe, the agency’s European profile will become even higher.

Meanwhile, the Conservatives have pledged to implement a strategy that will allow drug companies to launch new drugs through the NHS, but priced only according to the benefits they bring to patients. So-called value-based pricing, the party says in its healthcare policy, will encourage the NHS to use whichever medicines are clinically effective, rather than simply cost-effective. NICE’s role would then also involve negotiating with drug companies to set fair prices for medicines, rather than refuse new treatments that it deems not to be cost-effective.¹⁴

¹⁴ “Renewal: Plan for a better NHS”, Conservative Party policy document, 2009.



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supposed to commission," says Mr Barron, the Rother Valley MP. "They are very good at saying, 'are we doing things right?', but not at saying, 'are we doing the right things?'"

Mr Stout acknowledges that commissioning remains "a relatively underdeveloped technique", and adds that the NHS is currently working on developing necessary skills and capacity for commissioning. "It will evolve over time as we get better and more effective quality measures of healthcare, intervening when quality is low and linking the quality performance of different parts of the health service to the payment mechanism," he says.

Professor Alan Maynard, an economist at the York Health Policy Group in the Department of Health Studies at York University and chairman of York NHS Trust, says the NHS needs to get on top of the "enormous unexplained variations" in the patterns of care delivery within the system. One approach, he suggests, might be to impose financial penalties for wrong-site surgery, errors with drug doses and outbreaks of hospital-acquired bacterial infections such as *Clostridium difficile*. Moreover, he adds, the system will have to look much more closely at how it deploys resources.

"What has been happening over the past decade, in particular, is that the problems of the service have been papered over with lots of money," Professor Maynard says. "The biggest consumers of resources are the hospitals. Hospitals are often doing good evidence-based stuff, but they are also doing a lot of marginal stuff that only adds months to life. We need to shift resources in hospitals to end of life care but also out of hospitals to contain ever-increasing demand for chronic care by better community services."

At the same time evidence-based measurements of quality, another focus of the Darzi review, must be a central tenet supporting changes in the way healthcare is commissioned and provided, according to policymakers. As discussed, PROMs, as the first tangible example of evidence-based medicine to be enshrined in the healthcare system, will give policymakers some indication of the effectiveness of a particular medical procedure.



Key points

- NHS pay and pensions will be central to efforts to rein in costs
- More hard choices loom if the NHS is to avoid a blunt budgetary axe
- Better co-operation between stakeholders in the healthcare system would make allocation of resources easier

Squaring the funding circle

Even under the best-case scenario, health spending will slow dramatically from 2011, forcing the health service to identify cost savings, according to those interviewed for this report. While health experts are divided on whether the new stringency will reverse progress in areas such as waiting lists, most expect a freeze, if not reduction, in staff salaries after a decade of significant rises. In his pre-budget speech in December 2009, the chancellor of the exchequer, Alistair Darling said he would cap pay rises for all public sector workers—which include the NHS—at 1% for at least two years from 2011 and cap public sector pensions by 2012. The shadow chancellor, George Osborne, has also promised a public sector pension cap, which would affect doctors, if the Conservatives take power.

Such policy statements amount to a “quick initial hit”, according to Professor Maynard. “But the quality issues are really quite significant because if you start to cut people’s pay, you may affect motivation and affect treatment.”

But one area where money might clearly be saved, he argues, is by substituting expensive physicians with less costly nursing staff in certain situations. “You could bring in nurses to do a lot more functions,” he says. “Can nurses do anaesthesia? In the US, they have nurse anaesthetists. The Royal Colleges have hysterics about it, but the evidence shows not much difference in outcomes. I think it’s already a gradual process and the crisis will catalyse a more rapid change. Hospitals won’t be able to afford so many physicians—they are damned expensive. For £120,000 you can pay for three nurses.”

Economists, health officials and politicians are more reluctant to speculate on specific areas of healthcare that might suffer more from the funding axe, although Mr Appleby of The King’s Fund and Mr Sussex of the Office of Health Economics identify mental health as an area that has traditionally been neglected within the NHS and is likely to remain overlooked as resources become more scarce once again. Still, as Mr Sussex adds, “it’s hard to imagine any areas would be ring-fenced.”

In addition, although the Darzi review and other studies have identified the importance of shifting investment to public health and preventive healthcare in particular, economists and clinicians warn this will be no easy panacea for cost savings.

“A risk the government will take is that it will either end up costing more money or reducing the quality of care,” says Professor Gilmore of the Royal College of Physicians. “With ageing and the complexity of multi-system diseases, managing health in the community will not be the cheap option.”



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Meanwhile, an era of tight budgets is likely to exacerbate tensions and competition for scarce funding between hospitals and primary care as hospitals—particularly foundation trusts that have been allowed to keep funding surpluses—come under greater pressure to share their windfall with hard-pressed frontline primary care providers.

“I think the health service will continue to have an uncomfortable time while there remains confusion between the roles of, on the one hand, competition and contestability and, on the other, collaboration networks and pathways across care,” adds Professor Gilmore. “This confusion is mirrored by having some hospitals as foundation trusts and others not.”

Such conflicts could force renegotiations of contracts between PCTs and hospitals, much of whose work is covered by national tariffs, as financial pressures push the price for procedures down, notes Mr Stout of the NHS Confederation.

Caution on healthcare policy

Nigel Lawson, a former chancellor of the exchequer, famously quipped that the NHS was the closest thing the British had to a national religion. The remark was an apt one—the British are probably more likely to talk about how they feel about the NHS than they are to air their actual religious beliefs.

Opponents of the plans of the US president, Barack Obama, to introduce universal healthcare in the US pointed disparagingly at Britain's system, as an example of how healthcare ought not to be done. The British response was indignant, with political leaders of all stripes queuing to defend the NHS. However, all the main British political parties are perfectly aware that healthcare reform is as crucial here as it is in the US, and with a general election scheduled for 2010, pressure is mounting for them to reveal their policies.

Both Labour and the Conservatives have touted the need for cost savings in healthcare as well as in other sectors, but at the time of writing neither has yet been explicit in describing where they will come from. The Tories have pledged to shave one-third from the NHS's £4.5bn annual administration costs within four years of gaining power, and transfer the finds to “frontline services”, but they have not outlined in detail where the savings will be made beyond cutting red tape and refocusing the NHS on outcomes, rather than targets.

In a 2008 speech at The King's Fund, the Conservative leader, David Cameron, criticised the government's contracts with private diagnostic and treatment centres (DTCs) as being “11% more than the equivalent cost in the NHS”. His party's health policy repeats the figure, accusing the government of rigging the system in favour of the private sector—for example, by offering clinic operators a minimum income to guarantee their survival. However, the policy

also promises the creation of an NHS constitution, in which the NHS will work with other providers to provide a “seamless service” to patients.¹⁵

In a speech in September 2009, Labour's secretary of state for health, Andy Burnham, discussed the challenge of finding £15bn-£20bn of savings in the NHS's next spending review period, from 2011. Some of the savings, he said, could be achieved with a “multi-year tariff”. Reforms would come from within the system, he added, rather than from the top down, as had occurred in recent shake-ups. “We won't dictate to people how to make these savings—these decisions are better made on the ground,” he said.¹⁶

Mr Burnham said NHS Trusts' income would increasingly be linked to quality and levels of patient satisfaction, an indication that the patient-reported outcome measures (PROMs) scheme would be expanded under Labour. “This is a big culture change for the NHS, which has traditionally been paid by volume,” he said.

Mr Burnham believes that accountability guidelines would give underperforming NHS providers a chance to smarten up before opening up to collaboration with private partners. “I think the NHS can finally move beyond the polarising debates of the last decade over private or public sector provision,” he said. “The NHS is our preferred provider, but it is the important job of the commissioner to test whether these services provide best value and real quality.”

A further plank in Labour's policy would be to abolish “practice boundaries”, and allow patients to register at a surgery of their choice, rather than one near their home. The plan was broadly welcomed by the opposition and employer groups, but rang alarm bells at the British Medical Association.

¹⁵ “Renewal: Plan for a better NHS”, Conservative Party policy document, 2009.

¹⁶ Speech to The King's Fund, September 2009



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¹⁷ *From Feast to Famine: Reforming the NHS for an age of austerity*, Social Market Foundation, July 2009.

“What’s going to happen is that the pot of money available to the NHS we all know is going to be squeezed, and the money allowed for hospital care will be squeezed most,” says Mr Sussex of the Office of Health Economics, who predicts that waiting times and targets might “go slightly into reverse”.

Mr Appleby of The King’s Fund, among others, sees those options as politically fraught and says the public won’t tolerate a reversion to the 1980s, when the NHS closed wards and delayed care. It’s a sentiment echoed by the Social Market Foundation, which argues that the way to avoid this scenario is likely to involve both a strategic rationing of care and limited charges for those who can afford to pay. It calls for a new set of NHS values that safeguard the health service’s principles of equity and universalism, while also reflecting a “new understanding of the role and capacity of health services.”¹⁷

Meanwhile, recent efforts to allow foundation trusts to increase their levels of commercial activity beyond existing government caps on such work, have been stymied. The proposed amendment to the 2008/09 Health Bill, introduced in the House of Lords in November, would have allowed all foundation trusts to bring in an additional 1.5% of their overall budget from “private patient” work. The government has nevertheless launched a review of the cap and was taking evidence until the end of 2009.



Key points

- The role of private care providers in British healthcare has been small, but has stimulated innovation
- Assessments of the worth of some public-private schemes are mixed
- Patient choice will have a growing impact on the private sector's role

The progress of the private sector

Although private health spending has grown significantly over the past two decades, the private sector still accounts for a small share of the UK healthcare market in most areas outside of long-term care, and few analysts predict a major expansion over the next five years.

Yet a full analysis depends in part on how private healthcare is defined. On the expenditure side of the equation, the private sector accounts for just under 20% of the national health market, with just over 10% of the population carrying private medical insurance—12.3% if people with self-insured medical expenses schemes are taken into account. Meanwhile, private providers have made incremental, but significant, inroads into the area of health service delivery.

The Thatcher Conservative government began contracting out non-clinical services in the early 1980s. It later introduced the practice of funding new hospitals and other capital projects through private finance initiatives, or PFIs, in which private consortiums financed, designed and built hospitals and took on the operating contracts, for which hospitals paid them from their annual budgets. But it was in the late 1990s that the government set the precedent of paying the private sector for clinical services from the NHS budget—inviting private hospital groups, including international providers, to provide beds in private hospitals and operate diagnostic and treatment centres (DTCs) to help the health service clear waiting lists for elective and routine surgery.

The Mr Sussex of the Office of Health Economics says that the private sector has played a relatively modest role in British healthcare because politicians have not wanted it to play a greater one. However, he says that private providers have encouraged NHS hospitals to keep up with best practices. “The private sector is not only the generator of new ideas, but stimulates people to look for new ideas and to implement them.”

Mr Sussex's comments were backed up by a June 2008 report by the Institute for Public Policy Research, a think-tank, which argued that the most important role for private spending on healthcare was perhaps to create pressure for the NHS to improve its own standards—a factor that had led, in recent years, to debates about waiting times, choice and new treatments. The report said that while private spending would not solve the “health gap”, the role of the private sector ought not be overlooked by policymakers.¹⁸

¹⁸ *Private Spending on Healthcare*, Institute for Public Policy Research, June 2008



However, Mr Sussex and other commentators are less complimentary about PFI financing, which is seen as more expensive than public borrowing would have been. And other assessments of the overall success and impact of private sector health delivery within the NHS remain mixed. Professor Maynard of York University believes that any new government will continue to approach the private sector with caution, in part because there has not yet been a good enough analysis of the performance of initiatives such as independent treatment centres (ISTCs).

Questions over performance are one reason for the caution, but another is more basic—that greater private sector involvement in healthcare will erode the NHS's guiding principle of free healthcare for all citizens. Both proponents and opponents of the private sector's role in the NHS agree that as private providers gain increasing familiarity with the health service, many are well placed to expand into the potentially lucrative primary care sector. "If 80% of the commissioning budget held by the primary care trust can now be put out to the private sector, the question is what will remain free at the point of delivery," Professor Pollock of the University of Edinburgh, who is critical of the use of public funds for private healthcare.

Professor Pollock argues that citizens will remain committed to the public system. However, some recent polls suggest that the divide between those who see a role for the private sector in healthcare and those who don't is not as great as it might once have been. An Economist Intelligence Unit survey in mid-2009 found that 23% of Britons agreed with the idea that a greater role by private operators would improve their healthcare system, compared with 34% who disagreed.

At the same time, however, fewer than 25% of respondents said that they would be willing to pay fees at point of provision, or to insurers, for better care. Voters expect the cost burden to remain with the government—a crucial point for policymakers, as an election looms.¹⁹

One reason behind citizens' increased awareness of private healthcare may be the Department of Health's introduction of a system called Choose and Book, under which patients can select from a range of hospitals or clinics if they need to see a specialist.

David Worskett, director of the NHS Partners' Network, says that since Choose and Book was introduced in 2008, a growing number of people have elected to exercise their choice. According to

¹⁹ *Health reform: The debate goes public*, Economist Intelligence Unit, October 2009.

Slow growth, but opportunity

The private sector has not been immune to the effects of the recession, or to broader changes in healthcare policy. Half-year results to June 2009 released by Bupa, a British healthcare company, showed that the company—which has changed its core focus from hospitals to insurance—had lost customers as unemployment and recession forced people to give up their cover.²⁰ In January MDB, a market researcher, said that although spending on private healthcare had risen by 29% between 2004 and 2008, it grew by just 3% to £5.9bn in 2008. However, the researchers predicted that private medical insurance would grow

by 10% between 2008 and 2013.

David Stout, director of the Primary Care Trust network at the NHS Confederation, says the rate at which the private sector continues to grow in Britain will partly depend on whether it considers there is enough profit to make it worthwhile.

"If I were guessing, [it will be] a continuation of slow growth, but not massive exponential growth," he says. "ISTCs probably won't grow in number. The greatest area of development will be in community-based services, rather than in hospital-based ones. There's not as much capital investment needed, and more opportunities for fast-moving new service development."



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data from Lang & Buisson, a healthcare analysis firm, there were 134 hospitals on the Choose and Book system at June 2009. "It has begun the process of making this look like a consumer market," Mr Worskett says.

Mr Worskett points out that fewer than half of people visiting their GP are made aware of their right to choose, so the numbers of people likely to have their operation in a private facility will continue to increase.

However, he says, if patients felt that their local NHS hospital offered facilities and care to the same standard of a good private operator, they wouldn't choose to go anywhere else. "At the top of the public's concerns are hospital-acquired infections," Mr Worskett says. "I don't think there's any doubt at all that the interest people have in choosing a private sector hospital is that MRSA and *C. difficile* rates in private hospitals are virtually zero." Otherwise, he adds, patients perceive little difference between the quality of the NHS and that of private hospitals.

Claire Rayner, president of the Patients' Association, agrees that having a choice is increasingly important for British patients. In that regard, she says, the private sector is playing an important role as patients seek a more personalised level of service for certain operations. Meanwhile, people who opt to pay for their own treatment are removing some of the burden from the NHS.

However, Ms Rayner is critical of policies which she believes have forced NHS frontline medical staff to concentrate more on performance targets and less on patients. "Before Thatcher, everyone's attention was firmly fixed on the patient," she says. "Now, 40% of nurses' time is spent capturing data and filling out forms. The focus of all the attention is the spreadsheet, the targets and the money. It's unbelievable how much money is wasted in the NHS on layer after layer of excess management."

Ms Rayner is sceptical that more choice is best for everyone. "It sounds lovely, but it's a lot of codswallop", she says. "You live in a village in Yorkshire and you won't have a choice—it will be the nearest big hospital. Many people don't want polyclinics because they want to see their own GP, the one they've seen for years."

As patients have become more empowered and are presented with choices for their healthcare, opportunities for the private sector are more apparent. However, residual scepticism about the private sector's role in British healthcare—both among politicians and citizens—has led to a lack of clarity on policy in this area.



Conclusion

The reforms imposed on the UK healthcare system over the past two decades have transformed it and, arguably, fragmented the cohesion of the system at the same time. The past decade of additional investment in the health service has helped the UK to catch up with the rest of the European Union, but cultural change throughout the system has been slower in coming, and it remains unclear, at best, if there have been any long-term gains in quality.

In the medium term, clinicians and policymakers hope to use new data from initiatives such as PROMs as the basis for making decisions on how to allocate resources and treatment, with the new weight of evidence behind them.

But as the system faces its toughest funding environment in decades, along with the mounting pressures of an ageing population with complex chronic health needs, prospective reformers find themselves at a crossroads.

One prediction that can confidently be made about British healthcare over the next few years is that it will remain free at point of provision. Starting from this basis, it is possible to envisage reform of the system which relies less on fiddling with the institutions and structures of the health service, and more on changing its culture and getting to the root of how to advance the quality of care. Such an approach would focus less on performance targets and more on improving relations between different parts of the healthcare delivery system—public and private—and on empowering the local officials who commission contracts for service.

While every effort has been taken to verify the accuracy of this information, neither The Economist Intelligence Unit Ltd. nor the sponsor of this report can accept any responsibility or liability for reliance by any person on this white paper or any of the information, opinions or conclusions set out in this white paper.

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