

Summary

Success in delivering a high quality service is dependent not just on there being adequate resources, but on those resources being used to maximum effect. This chapter sets out a number of observations about the effective use of resources:

- setting national standards for clinical care and an integrated ICT system;
- establishing the right incentives and targets;
- finding the best balance between nationally-set standards and sensitivity to local circumstances to ensure the smooth delivery of a high quality service;
- finding the right balance between health and social care, primary and secondary care, and treatment and prevention so that health gains are maximised and people receive care in the most appropriate and efficient way;
- ensuring taxpayers' money is being used efficiently and effectively through regular and rigorous independent audit of all health care spending; and
- encouraging greater public engagement in order to increase levels of health awareness and establish a more effective partnership between the public and the health system.

This chapter also reviews consultation responses around the method of financing care and confirms the conclusion of the Interim Report that there is no alternative financing method to that currently in place in the UK which would deliver a given level and quality of health care either at lower cost to the economy or in a more equitable way. In the longer term, the issue is the sustainability of the individual components of the financing mechanism.

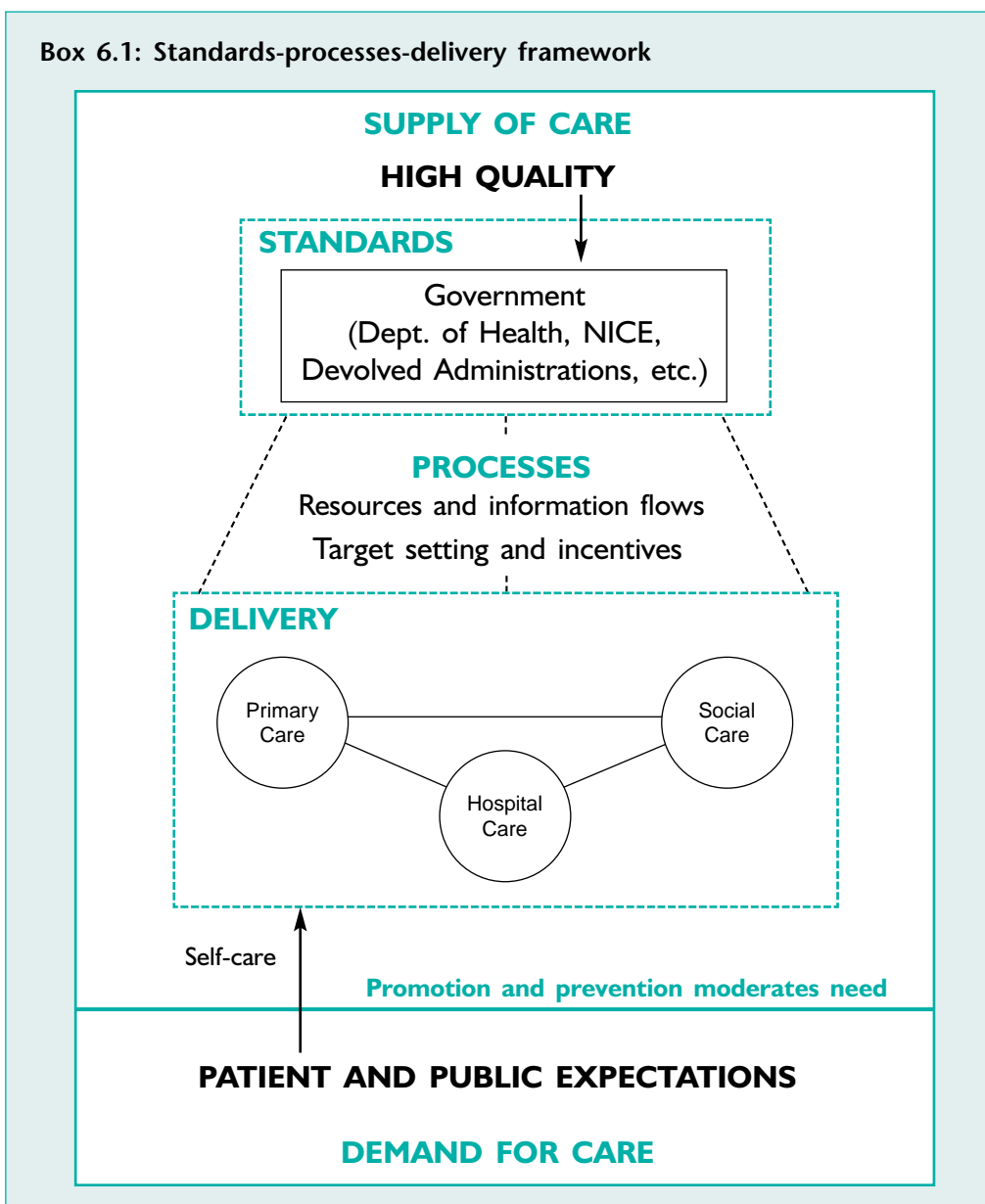
INTRODUCTION

- 6.1 Success in achieving a high quality health service will not be guaranteed simply by spending the amounts of money estimated in the previous chapter. Resources must be used effectively, not only to meet rising patient and public expectations but also to continue to justify the increasing level of expenditure being devoted to the health service, for which in one way or another the public is paying.
- 6.2 The Confederation of British Industry (CBI) backed this view in consultation, stressing that "increasing the level of funding alone would not be a panacea. Increased funding would have to be provided in return for reform and improved performance." The NHS will need to deliver and demonstrate the efficient use of its resources rigorously if it is to rise to the challenge.
- 6.3 The importance of deploying resources effectively is illustrated in the Review's scenarios. For example, there are significant differences in health outcomes between the *slow uptake* and *solid progress* scenarios. Government, those who work in the health service and those who use it all have a role to play in helping to ensure that health resources have the maximum impact on health outcomes.
- 6.4 In working through the modelling and in absorbing the views expressed in consultation, many issues arose about the ways in which resources are currently being used. That is rightly an issue for public debate. It is also the

main area in which political consensus would be valuable to give managers of health service resources a greater degree of certainty. This chapter sets out a number of observations in key areas which the Review hopes will help to inform the debate on the effective use of resources.

6.5 Box 6.1 sets out a conceptual framework of a structure determining how responsibilities could be fixed across the health service:

- **standards** are set by departments and agencies of government, essentially as a regulator;
- **processes** are the devices controlled by government designed to ensure that resources can be used effectively to achieve the standards; and
- **delivery** is the locally determined and controlled set of arrangements for the provision of care to meet the standards, working within the processes established. Generally it is at this local level that management of resources to achieve outcomes should take place.



STANDARDS

- 6.6 Standard setting plays an important role in any health system, by defining the objectives and priorities for the service and regulating quality in the delivery of care. If set clearly and openly, such standards provide the basis for allowing all those involved in the provision of health services to satisfy their “prime duty” (as the 1979 Royal Commission¹ put it) “to make it clear to the rest of us what we can reasonably expect”.
- 6.7 Standards should be set by the departments and agencies of government which oversee and regulate the health system. They should be well defined and transparent. Many of the standards set by government for the health service should inevitably focus on clinical standards – for example, defining the minimum quality of care which every citizen has the right to expect irrespective of where they live. But in some cases, there may also be a role for the central setting of non-clinical standards. For example, the Review believes strongly that information and communication technology (ICT) standards must be set firmly from the centre.

Clinical standards

- 6.8 Clinical standards will play two vital roles in the high quality service of the future outlined in this Report. First, by helping to match rising expectations and the effectively infinite demand for care to what can be supplied within finite financial and human resources; and second, by helping to ensure that what is supplied is both clinically and cost effective, delivering value for money for whoever is paying.
- 6.9 Judgements about what is clinically and cost effective are difficult and complex and are becoming more so as the pace of medical advance increases (particularly in cases where the gains to an individual may be significant, but where wider benefits to society will be at best limited).
- 6.10 In order to help make these judgements in a transparent, evidence-based way, the National Institute for Clinical Excellence (NICE) was established in 1999 covering England and Wales. There are two bodies in Scotland which together perform a similar function – the Health Technology Board for Scotland and the Scottish Intercollegiate Guidelines Network (SIGN). Northern Ireland is taking note of the judgements of NICE and a consultation exercise, undertaken in 2001, indicated support for a more formal relationship with the Institute. The current role of NICE is summarised in Box 6.2. The Review found a significant degree of interest in the work of NICE among people it met during its visits to other countries.

¹ Report of the Royal Commission on the National Health Service (1979), Cmd 7615, The Stationery Office, London.

Box 6.2: National Institute for Clinical Excellence (NICE)

NICE's aim is to provide everyone with an interest in health care – from health professionals and those commissioning health services, to patients and their carers – with authoritative, robust and reliable guidance on current best practice in health care, both in terms of individual health technologies (such as medicines, medical devices, diagnostic techniques and procedures) and the clinical management of specific conditions.

It provides three main types of guidance:

- technology appraisals of new and existing health technologies;
- clinical guidelines and protocols for the management of specific diseases and conditions; and
- safety and efficacy decisions about new interventional procedures.

In addition, it produces clinical audit methods to support the technology appraisals and clinical guidelines.

To date, NICE has published around 40 technology appraisals and five clinical guidelines.

- 6.11 The Review strongly supports the role of NICE and believes that it will become increasingly significant over the next 20 years. While NICE's remit covers both new and existing technologies, the focus of its work so far has inevitably been on newer technologies. However, the Review recommends that NICE, in conjunction with similar bodies in the Devolved Administrations, also has a major role to play in examining older technologies and practices which may no longer be appropriate or cost effective.
- 6.12 The Review also welcomes the current consultation² on proposed changes to the way in which the Department of Health and the National Assembly for Wales select appraisal topics for referral to NICE. The main purpose of these changes is to ensure that NICE's various stakeholders have clear opportunities to make an input into the selection process and that NICE's appraisal programme addresses the topics of importance to patients and professionals.
- 6.13 It will also be important to ensure that recommendations from NICE – particularly its clinical guidelines – are properly integrated with the development of National Service Frameworks (NSFs). As it develops, NICE should have a crucial role to play in establishing general principles to help the appraisal of technologies and is likely to form productive relationships with those charged with auditing responsibilities.
- 6.14 The Report has already discussed in Chapter 2 the existing NSFs and their implementation costs. The Review welcomes the proposed extension of the NSFs to other areas of the NHS. It recommends that NSFs should in future

² Department of Health and National Assembly for Wales (2002), Clinical guidance from the National Institute for Clinical Excellence – timing and selection of topics for appraisal, a discussion paper, March 2002.

include estimates of the resources – in terms of the staff, equipment and other technologies and subsequent cash needs – necessary for their delivery. They should also be supported by improved information collection and identification of research needs, to enable monitoring of progress and identification of future plans. The development of NSFs should also take account of the fact that many patients have – and may increasingly have – co-existing conditions, such as diabetes and coronary heart disease (CHD), complicating the definition of high quality treatment.

- 6.15 Taken together, the NSFs and NICE recommendations should form a sound basis for the setting of clinical standards in the health service over the next 20 years. Essentially, they will be defining (and keeping up to date the definition of) “comprehensive” in terms of the services the NHS offers all the population. The setting of these standards is an area in which the Review believes there is a strong argument for close collaboration between the Department of Health in England and its counterparts in Scotland, Wales and Northern Ireland.
- 6.16 An issue which could become more significant over the next 20 years is whether, as patient expectations rise (and provided capacity becomes less constrained) delivery units in the NHS should be able to consider providing treatments and procedures which have been turned aside by NICE on cost effectiveness grounds to patients who are willing to pay a full price for them. The Review believes that this will raise some difficult issues, but it has not been necessary to address them for the purpose of the estimates made in this Report.

Non-clinical standards

- 6.17 Standards should also be extended where appropriate to other dimensions of the NHS’s strategy for delivering a high quality service in an efficient and effective way. They should not only help to inform patients of what they can expect, but also provide the framework for the service to meet these expectations.
- 6.18 The Review believes that there is a particularly strong case for setting common standards in ICT. Chapter 3 describes the health service’s very poor record on ICT investment. There appear to be two key reasons why the state of ICT in today’s health service is as poor as it is:
- ICT budgets – which have traditionally been allocated locally – have frequently been used to fund other areas of spending to help relieve short-term pressures; and
 - there has been inadequate setting of ICT standards from the centre, resulting in a diverse range of incompatible systems across the health service.

- 6.19 These points came through strongly in consultation. The Royal College of Nursing called for stronger central direction on standards and accredited solutions to prevent resources being wasted in the future, while EDS (Electronic Data Systems) argued that the bulk of NHS ICT procurement is still undertaken at local level leading to expensive “reinvention of the wheel” and failure to take advantage of NHS purchasing power. They suggested the need to “ring-fence appropriate funding to deliver a National Information Infrastructure for the Health Service”.
- 6.20 The NHS Information Strategy³ in England and similar strategies and plans in the Devolved Administrations have defined ambitious targets for the use of ICT across the health service. For example, the NHS Information Strategy sets out the intention that, by the end of this year, hospitals and GPs should be routinely exchanging electronic requests for referrals, discharge summaries, and laboratory and radiology requests and results. By 2005, it is planned that there will be an electronic patient record system for all acute hospitals, integrated primary and community care records, and 24-hour emergency care access to patient records.
- 6.21 Chapter 3 sets out how the Review’s projections incorporate a doubling of spending on ICT to fund ambitious targets of the kind set out in the NHS Information Strategy. However, before committing to such significant increases in spending, a number of important points will require careful consideration:
- the Government and the health service must ensure that they have clear and well developed views about the benefits which they want to achieve and how they will be delivered, with patients at the core of the system. The implications for staff training will also need to be considered carefully;
 - to avoid duplication of effort and resources and to ensure that the benefits of ICT integration across health and social services are achieved, the Review recommends that stringent standards should be set from the centre to ensure that systems across the UK are fully compatible with each other; and
 - to ensure that resources intended for ICT spending are not diverted to other uses, and are used productively, the Review recommends that budgets should be ring-fenced and achievements audited.
- 6.22 If these issues can be addressed, the Review believes that national, integrated ICT systems across the health service can lay the basis for the delivery of significant quality improvements and cost savings over the next 20 years. Without a major advance in the effective use of ICT (and this is a clear risk given the scale of such an undertaking), the health service will find it increasingly difficult to deliver the efficient, high quality service which the public will demand. This is a major priority which will have a crucial impact on the health service over future years.

³ Department of Health (2001), Building the information core – implementing the NHS Plan, NHS Information Strategy.

PROCESS AND DELIVERY

Incentives and targets

- 6.23 Appropriate processes must be in place to ensure that the nationally-set standards are delivered by the health service. There are many cases where this has not happened and standards of care delivered have fallen short. The vision of the health service in 20 years' time set out in this Report cannot permit this, so the processes of objective setting, incentivisation and targeting have to be sensitively designed to ensure they achieve the required results rather than distort resource allocation.
- 6.24 There are a number of aspects to such 'processes'. They particularly relate to the way in which resources and information flow around the system and in which incentives and targets are used to direct the delivery of efficient and effective levels of care. The flows are vertical, between those setting standards nationally and those delivering them locally, and horizontal, between the different health and social care providers locally.
- 6.25 There is a fine balance to be struck in deciding on the most appropriate way to ensure that central standards are achieved across the service. The setting and auditing of targets is one means which can be used. Financial incentives are another. In consultation, the Association of the British Pharmaceutical Industry commented that "we are strong believers in the maxim 'you get what you measure'. This makes it critically important that any measures used to assess performance in the NHS be meaningful, and measure outputs rather than inputs."
- 6.26 The Government has introduced a number of incentives in an attempt to encourage greater flexibility, for example steps towards 'earned autonomy' for the best performing NHS bodies. This provides those NHS Trusts with a three star performance rating with extra discretion in spending from the NHS Performance Fund and other flexibilities, including less frequent monitoring from the centre, fewer inspections and scope to retain more of the proceeds of local land sales for re-investment in local services⁴. This is an encouraging first step, albeit based on a relatively simplistic measure of performance.
- 6.27 The Government has also set a number of headline targets for the health service, the most high profile being targets for reducing waiting times. Longer-term targets focus on reducing mortality rates from the major killers such as CHD and cancer and narrowing health inequalities.

⁴ Department of Health (2001), NHS Performance Ratings Acute Trusts 2000-01. www.doh.gov.uk/performance/ratings

- 6.28 But targets must be used with care, especially in a service as complex as the NHS. In particular, they must be designed to minimise the risk of creating perverse incentives. In addition, where targets are not achieved, the reasons must be examined carefully and in the context of the whole performance of the unit concerned. In some cases there may be valid reasons why a target was missed which should, for example, result in a re-examination of the specific target rather than any penalty being incurred by the service provider.
- 6.29 In this respect, the Review was interested in work currently being undertaken by RAND Health⁵ to develop a new approach to assessing the quality of care given to children and adults in the US. This addresses quality across a full range of care from screening and diagnosis, to treatment and follow up in 46 different clinical areas. The benefit of such a broad approach to assessing quality is that it takes account of and highlights the wide range of activities and trade-offs which every health care provider has to make. A potential disadvantage is that by spanning such a wide range of indicators health care providers might lose sight of the key priorities. Nevertheless, the Review recommends that the results of this and any similar research about comprehensive measurement of performance should be examined.

Delivery

- 6.30 Finding the balance between nationally-set standards and an appropriate sensitivity to local circumstances will require local discretion to be enhanced. The sheer scale of the NHS makes this vital and there is widespread commitment to making changes in health care delivery, coupled with the recognition that this will only happen through staff on the front-line.
- 6.31 To support this process, resources must be allocated by government in a way which is transparent, takes account of local needs and does not create perverse incentives. Stability and certainty of funding is also important to facilitate long-term planning and investment decisions. A concern frequently expressed to the Review was that the annual resource allocation process is too drawn out and that health care providers have neither the capacity nor the time – often at short notice – to bid for particular allocations of money from the centre.
- 6.32 The health service has been through many reorganisations over the past 20 years, the most recent having taken effect at the beginning of this month with the establishment of 28 Strategic Health Authorities (StHAs) for England. The StHAs will officially take up their role in October 2002, replacing the previous 95 health authorities. The challenge now must be to ensure that this new structure works effectively and involves a high degree of accountability and public involvement at local level. As the Healthcare Improvement Network put it in consultation, “the NHS needs to transform into an organisation that uses resources effectively and accountably and is continuously improving”.

⁵ RAND Health, Quality Assessment Tools and Technologies, The First National Assessment of Quality, www.rand.org/health/tools/qualist.html

- 6.33 The required transformation will need strong management and a willingness to break down some long standing barriers in the health service. Some of these relate to the use of the workforce. In a situation where the NHS needs more highly skilled staff, not only must it recruit and train more of them, but it should ensure that those it already has are being used to full effect. The Interim Report highlighted evidence that relatively little of doctors' and nurses' time was spent with patients. Consultation provided little further specific evidence on this point. The service needs to ensure that its skilled medical and nursing staff are able to spend as much of their time as possible with patients.
- 6.34 The Review agrees that there is significant scope to give more local discretion to those delivering care to nationally set standards. Such flexibility lends itself to maximising the effectiveness of resources. It facilitates the development of innovative approaches and the sharing of best practice, helping to drive up performance across the board. This is a key potential benefit of the decentralisation process, enabling alternative policy approaches to be compared. Devolution of health policy in Scotland, Wales and Northern Ireland has provided further scope in this respect. NHS staff who met the Review team frequently expressed the view that there should be greater local responsibility for delivery, ensuring an appropriate balance between central direction and local autonomy.
- 6.35 The first annual report of the NHS Modernisation Board⁶ makes clear the need for everyone to embrace change on a massive scale, fundamentally shifting working practices and attitudes, some of which have remained unchanged since 1948. It reports good progress in many areas but acknowledges the many enormous challenges to be overcome. It concludes: "in nearly every health community, in the first year, there have been examples of progress which is a significant cause for optimism. But it is perhaps inevitable that so far modernisation is patchy and there is clearly still a long way to go".
- 6.36 The CBI response notes that the Government is making progress to improve the efficiency and effectiveness of health care provision through initiatives to "improve how it works with the private sector, becoming a more challenging and partnering client, developing new areas of collaboration...". The Review agrees with this sentiment and believes that the scope for greater future cooperation between the NHS and the private sector in the delivery of services should be explored, building on the concordat set out in the NHS Plan. This should be seen as just one of the many ways in which the health service – like any organisation – is constantly examining new ways of working to deliver its objectives more effectively. The method of delivery should not be confused with the method of financing.

⁶ The NHS Modernisation Board (2002), The NHS Plan – A Progress Report, The NHS Modernisation Board's Annual Report 2000-2001, January 2002. www.doh.gov.uk/modernisationboardreport

- 6.37 In devolving greater responsibility to the local level there must be strong arrangements for ensuring a high degree of accountability for the effective use of resources. One aspect of this is the role of public engagement discussed later in this chapter, ensuring that people are aware of, and involved in, the decisions being made about health care in their local areas. But there is also a responsibility on government to ensure that taxpayers' money is being used efficiently and effectively across the health service. The Review recommends there should be a mechanism in place to ensure regular and rigorous independent audit of all health care spending and arrangements to ensure it is given maximum publicity.

THE BALANCE OF CARE

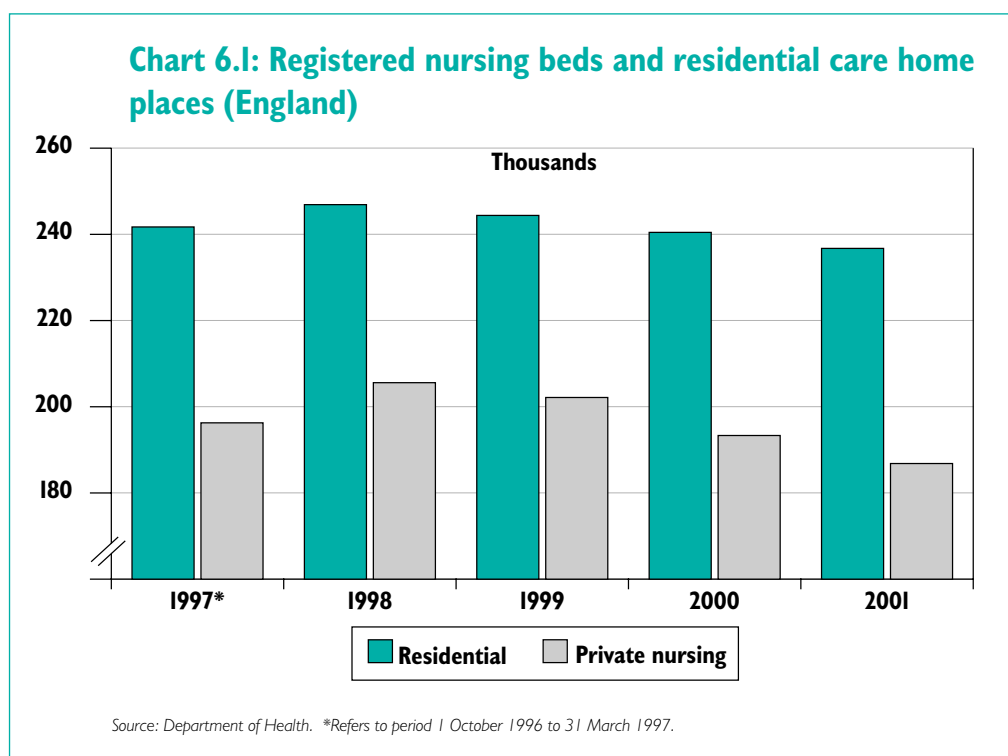
- 6.38 Over the next 20 years, ensuring that care is of a high clinical quality and provided with minimum waiting will not be sufficient to meet patients' demands. Care must also be provided in the right place and at the right time. This requires striking an appropriate balance between different types of care – in particular, between health and social care, between primary and secondary care and between treatment and prevention. The latter is discussed in the section on public engagement at the end of this chapter. In its financial modelling, the Review has not attempted to map out in a detailed way how the balance of care might change over the next 20 years, although some of the possible key developments such as a greater focus on public health are considered in the scenario analysis.
- 6.39 Ensuring that the health service in 20 years' time strikes the right balance will require making sure that its processes work and that there is effective integration between the different types of care, driven by appropriate incentives and efficient flows of information.

Health and social care

- 6.40 The Review believes the current balance between health and social care is wrong: in particular, care is too focused on the acute hospital setting. Acute care should only be needed in the event of serious ill health. As acute care beds are the most costly beds in the NHS – at around £120,000 a year each – only those patients who need to occupy them should do so. This point was made by a number of organisations during the consultation process. In visits to NHS hospitals, it was clear that alternatives to acute care are often lacking.
- 6.41 There is no doubt that some patients spend more time in acute care than they need or indeed wish to. The number of people whose discharge from an acute hospital bed was delayed while awaiting more appropriate care elsewhere has been falling in recent months. Nevertheless, in England, it still stood at 4,500 in March 2002⁷. This inappropriate use of beds – so called 'bed blocking' – impacts on both the overall quality of care which an individual receives and on the cost effectiveness of care more generally. The bottom line is that these valuable resources are not available for those who really need them.

⁷ Department of Health (2002), Chief Executive's Report to the NHS (April 2001 – March 2002).

6.42 The main causes of delayed discharges are patients waiting for assessment or waiting for funding for a nursing home or residential care placement. Such delays stood at 10.5 per cent for patients aged over 75⁸ in the period between October and December 2001. Effective integration between health and social care, supported by the right financial incentives, is the key to tackling such delays. The NHS Confederation referred to the “problems resulting from the allocation of health and social care funding through different mechanisms”. These problems need to be tackled if the NHS and social care are to provide a properly integrated service.



6.43 The number of social care places has been falling. Between 1998 and 2001, the number of private nursing beds⁹ fell by 9.1 per cent (almost 19,000 beds) and residential care places¹⁰ fell by 1.9 per cent (6,700 places). This is shown in Chart 6.1. Councils and care home owners are arguing for higher fees. Appropriate financial incentives are required to sustain a viable nursing and social care home market. The need for regulation and improved standards must be balanced with stable financing to support the quality of care.

⁸ Department of Health (2002), Quarterly return October – December 2001, February 2002. Relates to the number of people aged 75 or over whose hospital discharge is delayed as a percentage of the number of people aged 75 or over occupying an acute hospital bed.

⁹ Department of Health (2002), Community care statistics 2001 – private nursing homes, hospitals and clinics, statistical bulletin 2002/09, March 2002.

¹⁰ Department of Health (2001), Community care statistics 2001 – residential personal social services for adults, England, press release 2001/0577, November 2001.

- 6.44 The Review has noted Sweden's success over the past decade in reducing bed blocking. The 1992 Ädel reforms in Sweden introduced financial incentives to reduce the number of elderly patients waiting to be discharged from acute care hospitals. Under these arrangements, the local authorities (which are responsible for social care) are required to pay the county councils (which run the hospitals) for care delivered to patients in hospital once a patient has been deemed fully medically treated by a hospital doctor.
- 6.45 The Review acknowledges that such a system could lead to the creation of excess capacity in social care. But it demonstrates the importance of taking a 'whole systems' approach and that investment in health care must be accompanied by adequate investment in social care. Recent additional resources for social care to ease bed blocking are therefore welcome. The Review recommends that the Government should examine the merits of employing financial incentives such as those used in Sweden to help reduce the problems of bed blocking.
- 6.46 Within acute care, there are not just delays at the end of a period of treatment. Delays can also occur at the beginning of a hospital stay in identifying appropriate care needs and carrying out a range of tests. Part of the explanation for this is a lack of spare capacity. For example, without sufficient capacity in technologies such as scanners, essential medical tests which are required before treatment can commence may be stretched out over a longer period than necessary. In some cases, a shortage of skilled staff to operate the equipment exacerbates the problem. As an acute bed costs the NHS over £300 a day, this can act as a serious drain on resources. Again a 'whole systems' approach when making investment decisions about resources is needed.

Primary and secondary care

- 6.47 The Royal College of General Practitioners noted that "between 85 and 90 per cent of all consultations with patients take place in primary care rather than in the hospital setting" with primary care providing "the vast majority of medical and nursing input to patients".
- 6.48 The balance between primary and secondary care is also being changed by recent NHS reforms. GPs and nurses in Primary Care Trusts (PCTs) now control around 50 per cent of the NHS budget in England and this figure is set to rise to 75 per cent by 2004. PCTs are responsible for improving the health of the community, developing primary and community health services and commissioning hospital care for their local populations. As discussed later in this chapter, the new role for PCTs in controlling health care locally should offer the opportunity for greater transparency and public engagement in local health issues.

- 6.49 Currently most assessment and treatment of patients in primary care is carried out by general medical practitioners. The Review received views on the extent to which the role of nurses should expand to take on a wider range of clinical work. While the benefits of having continuing care from a GP are high, research¹¹ indicates that there is also a need to reassess what work could be undertaken by nurses and other health care professionals, including therapists and pharmacists. This would not be to diminish primary care but to augment it, with a much wider range of routes for patients to take advice, more diagnostic equipment and more treatment options.
- 6.50 The current position in the UK can be contrasted with, for example, the system run by Kaiser Permanente in California, where both doctors and nurses in primary care are accredited with a much wider range of skills¹². As a result, relatively complicated procedures are dealt with in primary care settings (albeit very different to the typical UK primary care setting), which frees up specialists in secondary care to focus on more complex cases. This is likely to be one of the reasons why Kaiser's average number of acute bed days per 1,000 of the population is significantly lower than that of the NHS.
- 6.51 The Review does not suggest that Kaiser's approach could or should be transferred to the NHS. But it does illustrate that, driven by a modern workforce skill mix, there could be considerable scope for a shift in the balance between primary and secondary care. While this is only one example, wider research¹³ also suggests that a greater proportion of diagnosis and treatment could take place in primary care settings, so reducing the time patients spend in acute care.
- 6.52 As Chapter 5 discussed, the primary care workforce will play an increasingly important role in the health service over the next 20 years, particularly in encouraging public engagement, for example, by supporting self-care or promoting improved public health.
- 6.53 Taking the case of diabetes as a case study, Box 6.3 considers how the balance of care could shift significantly over the next 20 years.

FINANCING OF CARE

- 6.54 The Review was established to estimate the resources needed to deliver a high quality health service over the next two decades. Its remit was not to look at how those resources should be financed. Nevertheless, it has been important to examine whether the way health care is financed might itself be a driver of the total resources required.

¹¹ Kinnersley P, Anderson E et al (2000), Randomised control trial of nurse practitioner versus general practitioner care for patients requesting same day consultation in primary care, *British Medical Journal*, 320: 1043-1048.

¹² Feachem R, Sekhri N et al (2002), Getting more for their dollar: a comparison of the NHS with California's Kaiser Permanente, *British Medical Journal*, 324:135-43.

¹³ Starfield B (1994), Is primary care essential?, *Lancet* 8930:1129-33.

Box 6.3: The care of diabetes in 2022 – a case study

Diabetes provides a good example of how a 'whole systems' approach could work in future. A National Service Framework (NSF) is currently being used to establish standards and monitor quality of care. As it is a risk factor for CHD, stroke and kidney failure, diabetes links across NSF areas: tackling it at root would help to prevent these diseases as well. It exemplifies how all the aspects of health promotion and health care interact and demonstrates the importance of looking at all points of the 'patient journey.' Key facts about diabetes include:

- 3 to 5 per cent of the adult population has diagnosed diabetes. This is predicted to rise due to trends such as the ageing population, dietary changes and reduced activity. There are also up to 1 million people with undiagnosed diabetes in the population;
- Type 1 diabetes is increasing in children and Type 2 diabetes is becoming more common in children, particularly within South Asian populations. Prevalence of Type 2 diabetes within the black and ethnic minority population can be as much as three to five times higher than in the white population; and
- undiagnosed and poorly managed diabetes can lead to serious complications such as blindness, amputation or even death. Prevention of diabetes and its complications is the best way of dealing with the escalating costs of the condition.

Over the next 20 years, there appears to be scope for significant cost savings as well as – more importantly – avoiding the human costs of the disease including sometimes fatal complications. Generating such benefits will, however, require action across many of the fronts which are raised as issues in this chapter and elsewhere in the report:

- **public health:** better diet and increased physical activity should help to reduce the prevalence of obesity, a key risk factor for diabetes. Reductions in socio-economic inequalities will also be important;
- **public expectations:** greater awareness of diabetes will increase demands for top-quality treatment. People with diabetes are 'expert patients' due to the chronic nature of their condition, proactively seeking information and making frequent contact with the health service. It will need to live up to their high expectations, providing them with good information and responding to well-informed questions about treatment and care;
- **primary care:** enhanced awareness of diabetes in primary care could lead to earlier diagnosis and improved diabetes management to prevent complications;
- **self-care:** new technology will allow better testing by remote monitoring or telemedicine. Call centres will phone to remind people to test their glucose levels. Improved access to health education would also help people to maintain the right blood glucose and blood pressure levels;
- **information and communication technology:** in particular, an accessible Electronic Health Record could transform diabetes care, preventing treatment errors and improving patient safety, through improved service co-ordination across the whole system; and
- **workforce:** practice nurses and community pharmacists could use their skills in diabetic care, saving GPs' time and giving a more specialised educational role for secondary care.

- 6.55 Chapter 4 of the Interim Report considered this issue and concluded that the current method by which health care is financed through general taxation is both fair and efficient and that “a continuation of a system of funding broadly similar to that at present is not, in itself, anticipated to be a factor leading to additional resource pressures over the next 20 years”. The Interim Report took the view that “it is therefore appropriate to conduct the Review on the basis of a continuation of the current system for funding UK health care”.
- 6.56 The Interim Report identified four main mechanisms for financing health care:
- **general taxation:** general taxation revenues, incorporating both direct and indirect tax receipts, collected by government;
 - **social insurance:** earnings-related employee contributions and/or employer payroll taxes;
 - **out-of-pocket payments:** payments made directly by patients for the use of particular health services in either the public or private sector; and
 - **private insurance:** private medical insurance taken out by individuals or by employers on their behalf.
- 6.57 Most countries use a combination of these to finance their health care systems, although the balance differs between countries. The UK and Sweden have the highest share of public funding: in both, under a fifth of total health spending is privately financed, compared to between a quarter and a third in the other comparator countries considered in Chapter 5 of the Interim Report.
- 6.58 Drawing on evidence from these comparator countries, the Interim Report considered the four financing mechanisms against three objectives: efficiency, equity and choice. A summary is provided in paragraphs C.15 to C.24 of Annex C.

Consultation views

- 6.59 The consultation responses generally supported the Interim Report’s conclusions about the efficiency and equity of general taxation financing and that the current mechanism of funding health care in the UK is unlikely itself to be a driver of cost. Strong support for a continuation of the current financing system was received from some respondents. The King’s Fund recently stated that “on the grounds of equity and efficiency of collection, the existing financing arrangements – predominantly through general taxation – are currently the best way of paying for health care”¹⁴. UNISON “supported the broad conclusions of the Review, i.e. that the NHS... should continue as a tax funded service.” However, a few responses questioned the Interim Report’s conclusions.

¹⁴ King’s Fund (2002), The future of the NHS: a framework for debate, discussion paper, January 2002.

- 6.60 Some claimed a causal link between financing health care predominantly through general taxation and the historic under-investment in the health service. For example, the Association of British Insurers said that “the UK’s publicly financed health care system has been associated with a significant cumulative under-investment in resources, infrastructure and poor service provision”. While there has undoubtedly been significant under-investment in the NHS in the past as a result of the failure of successive governments to commit sufficient resources to the health service, the Review does not believe that this is an inevitable feature of tax-financed systems. For example Sweden, which has a predominantly tax funded system, is not generally considered to have suffered from such a problem. Levels of health care spending vary significantly across countries irrespective of the particular financing system used.
- 6.61 It was suggested that the UK’s method of financing health care hides the real cost of health care, so impacting adversely on patient responsibility and engagement. The funding of health care from general taxation does obscure its cost, but it is not evident that a greater exposure of patients to the costs involved would necessarily lead them to take more responsibility for their own care. People covered by social and private insurance systems are more directly aware of the amount they are paying but there is no evidence that this constrains demand. In systems such as France where patients face direct charges they often take out additional insurance to cover these costs. The Review accepts that it is important that the public should be better informed about the cost of delivering health care. This is discussed in more detail in the public engagement section below.
- 6.62 It was also suggested that, in private or social insurance schemes, where people choose regularly whether to stay with their existing insurer or move to another, they could exert more influence over what is provided, could show their willingness to pay more for better services and could help exert discipline on total spending. The Review accepts that these are possible benefits although it appears not to have been the recent trend in many countries. For example, benefits packages tend to be the same or very similar across social insurance funds and, as noted in the Interim Report, cost containment has been a growing issue in many countries. The governments of France and Germany have been trying to limit the growth in social insurance contributions.
- 6.63 It has also been suggested that the UK’s method of financing restricts patient choice and limits the responsiveness of the service. The major private medical insurers and some research groups made this point strongly in consultation. The Review believes it is entirely appropriate that under a publicly-funded system choices about what clinical services are and are not provided should be made centrally and transparently on the basis of best available evidence. In England and Wales, this is the developing role of NICE.
- 6.64 But in any insurance system there will be rules laid down about what is and what is not covered. Private providers are free to make their own decisions,

and provide choice about what is covered. In terms of non-clinical services, the Review recognises that people will increasingly demand greater choice and responsiveness, and that financing greater choice in this area through general taxation may be neither acceptable nor equitable. As discussed below, introducing charges for certain additional non-clinical services would be one way of expanding the degree of choice.

- 6.65 It should also be noted that in the UK in the past, and at present, the opportunity for introducing greater choice has been restricted by a lack of capacity in the system. If such capacity constraints can be alleviated in the period ahead, this will open up the possibility of introducing greater choice across the service. The Government has made clear its intention to do so and it is certainly necessary (see Box 2.1). The Review accepts that it will require patients expressing their views to ensure this happens efficiently and in an appropriately responsive way.
- 6.66 The points presented above are all important, although some appear to relate more to the particular experience of the UK in the past than to inevitable consequences of the health care financing mechanism. The Review has carefully analysed the views which were put to it in meetings and in written submissions. It has considered the administrative burden of any changes at a time when the NHS is under such pressure for change. It is clear that there are deeply held beliefs about the extent to which private financing should exist in health care and that other countries, notably Canada, are engaged in similar debates over the best way of funding health care. However, the Review still does not believe that there is an alternative financing method to that currently in place in the UK which would deliver a given level and quality of health care either at lower cost to the economy or in a more equitable way. The issue is the sustainability of the individual components of the financing mechanism, and that needs to be addressed in the context of long-term estimates of the resource requirements.
- 6.67 The projected resource requirements for the health service over the next two decades set out in the previous chapter are very high and, should subsequent reviews confirm projections of similar magnitude, they will clearly present significant financing challenges. As expectations and quality standards rise, there will also be significant challenges in defining both clinical need and what level of patient choice can and should be accommodated through public funding.

Out-of-pocket payments

- 6.68 Out-of-pocket payments could play a role in meeting this challenge, both in terms of generating extra income for the service and in terms of providing extra choice for patients.
- 6.69 What role such payments should play in the future is not a matter for this Review, but for the government of the day. As noted in the Interim Report, decisions on the balance of financing should, on a continuing basis, be addressed in the context of the macroeconomic background against which

the Chancellor considers the implications of the estimates of future resource requirements for the Government's wider economic and fiscal strategy and, in particular, considers the capacity of the UK's general taxation base.

- 6.70 Whatever role they do play, however, such charges should only be considered in cases where the principle that access to health care should be based on clinical need and not ability to pay can be assured. With this in mind, two factors are particularly important in considering the possible role of such payments: the scope of charges and the exemptions applied for those who cannot afford to pay.
- 6.71 Charges already exist in the UK for a limited number of clinical services (mainly prescriptions, dental treatments and sight tests, glasses and contact lenses) and non-clinical services (for example, single maternity rooms, televisions, telephones and car parking).
- 6.72 The Review remains of the view that it would be inappropriate to extend out-of-pocket payments to clinical services such as visits to a GP or a specialist. As discussed in the Interim Report, such charges are inequitable unless accompanied by adequate exemptions and risk increasing inequalities in access to care. A few responses advocated such charges but NACAB's work on patient charges argued strongly against them¹⁵. While they could yield substantial revenues, they would also involve additional administrative costs.
- 6.73 The impact on equity of out-of-pocket payments for items, such as prescriptions, depends on how effective a safety net is in place to exempt all of those who cannot afford such payments.
- 6.74 Currently 50 per cent of the population of England is exempt from prescription charges, including the young, the elderly, the unemployed and those on low incomes. As a result, 85 per cent of prescription items dispensed by community pharmacists and appliance contractors in England in 2000 were free to patients. Yet in consultation, NACAB pointed to research commissioned from MORI showing that of those liable to pay, 1 in 20 had failed to get all of a prescription dispensed and a further 1 in 50 had failed to get part dispensed, because of the cost. On the other hand, some of those who are exempt could easily afford to pay and are unlikely to be deterred by the level of charges, especially as they are capped by pre-payment certificate arrangements.
- 6.75 Recognising the political sensitivities and the limited amount of money which might be raised, this may not be a priority for attention. However, the present structure of exemptions for prescription charges is not logical, nor rooted in the principles of the NHS. If related issues are being considered in future, it is recommended that the opportunity should be taken to think through the rationale for the exemption policy.

¹⁵ National Association of Citizens Advice Bureaux (NACAB) (2001), *Unhealthy charges: CAB evidence on the impact of health charges*, July 2001.

- 6.76 The Review believes that there is an argument for extending out-of-pocket payments for non-clinical services and recommends that they should be kept under review. Such services are likely to become more important as demand for greater patient choice increases and it may prove difficult to justify the public financing of such services. For example, payments could be considered for the provision of IT facilities in patients' rooms. This would offer a way of allowing patients to experience a greater choice in non-clinical services while at the same time enabling the health service to preserve its resources for clinical services. Better information technology will help to ensure that increased administrative costs do not use up the incremental income.

PUBLIC ENGAGEMENT

- 6.77 Prevention, diagnosis and treatment have from the outset been the goals of the NHS. The extent to which resources across the health service are deployed effectively will have a significant impact on each, and particularly on the second and third. But the degree to which the public engages with the health service will also have a significant impact, particularly on the first.
- 6.78 The importance of public engagement is incorporated into the Review's three scenarios (see Chapter 3). The core difference between the health outcomes in the *fully engaged* and *solid progress* scenarios is not the way in which the service responds over the next 20 years, but the way in which the public and patients do.
- 6.79 A public fully engaged on health issues will impact on the health service in many ways. Some have been picked up in the Review's analysis, in particular of increased health promotion and disease prevention, self-care and health seeking behaviour. At one level, engagement could extend, for example, to more people giving blood or carrying organ donor cards. At another, it could involve the public demanding a much greater understanding and role in decisions affecting the organisation and delivery of their local health services.
- 6.80 Effective public engagement will require an active partnership between those who provide care and those who receive it. The traditional relationship has been a passive one, which can be characterised by health professionals providing care to a generally deferential and uninvolved public, based on an underlying assumption that medicine, and those who practice it, can solve all medical problems. The emergence of a more aware public and evidence of clinical failure has, rightly, started to challenge this assumption and is likely to have wide implications, for example in an increasing desire by patients to have second opinions.
- 6.81 The Review therefore believes that a more sophisticated partnership will need to develop over the next 20 years, and indeed is beginning to do so. This view is not new, and has been suggested in a variety of quarters. For example, the British Medical Journal has suggested that over time the traditional relationship has developed into a 'bogus contract' between doctors and

patients, and that it is time for “something more real”, based on a more realistic understanding on the possibilities – and limits – of what health care can achieve¹⁶.

Rights and responsibilities

6.82 A more effective partnership is recommended, based on the twin planks of public and patient rights and responsibilities. This partnership should be focused on a new relationship between health professionals and the public, driven by government and arising from the patient-focused service set out in this Report. For example:

- the setting of standards for the service, as discussed above, to help give people a clearer understanding of what the health service will, and will not, provide for them;
- development of improved health information to help people engage with their care in an informed way. The piloting of NHS Digital TV and advice through NHS Direct are examples of this;
- use of pro-active policies, in parallel with improved information, to encourage reductions in key health risk factors;
- reinforcing patient involvement in NHS accountability arrangements, through measures such as Patients’ Forums, the English National Commission on Patient and Public Involvement and better patient representation on Trust Boards, including the new Primary Care Trusts; and
- finding effective ways to provide the public with a better understanding of how their local health services are performing.

6.83 Such developments should enable patients to become more engaged in an informed way. It will help to provide them with a clearer picture of what they have the right to expect from the health service. In this respect, it is encouraging to note that the NHS Modernisation Board will be exploring the idea of a ‘contract’ between the NHS and local communities. Under this contract, PCTs will set out where the money goes at a local level, put forward their specific proposals for spending in the future and detail what the money will deliver¹⁷. Ensuring an appropriate role for community representatives on the Boards of the new StHAs will also be important. The Review recommends that these Boards should include local patient and business representatives. The business community has a strong interest in a healthy local community and could help bring much-needed skills in resource management as increased local discretion changes the role of delivery units.

6.84 There is also a role for business to play in managing sickness absence from work and providing, wherever possible, high quality occupational health services.

¹⁶ Smith R (2001), *British Medical Journal*, editorial, 5 May 2001, 322:1073-1074.

¹⁷ Department of Health (2002), press release 2002/0167, 1 April 2002.

- 6.85 People have responsibilities to go along with such rights. In particular, they should seek to use health services responsibly and ensure that their actions do not add unnecessarily to the costs of the service.
- 6.86 To facilitate this, there needs to be better public understanding of the costs of delivering the health service. That is not to say – as some have advocated – that a patient should be told how much each appointment or course of treatment has cost. The administrative costs of such a system would be prohibitive. However, the Review recommends that as part of improved public engagement, the Department of Health (with StHA involvement) and the Devolved Administrations consider how a greater public appreciation of the cost of common treatments and appointments could best be achieved. There may be many ways to help focus public attention on the costs of the service.
- 6.87 Missed appointments impact seriously on the health service’s ability to plan and deliver timely care. In 2000, 1.56 million out of a total of 12.5 million outpatient appointments were missed – a rate of 12.5 per cent. Data are not available for missed GP appointments. For illustration, a rate of 12.5 per cent would equate to over 30 million missed GP appointments each year – or around 600,000 a week.
- 6.88 The health service currently tends to build in an element of over-booking based on average non-attendance levels. But on a day-to-day basis, non-attendance varies. If it is higher than average, this risks under-utilising health professionals’ time on the day; while, if it is lower than average, this risks extending patient waiting times on the day. Both impact on the efficiency and quality of the service.
- 6.89 The Review therefore believes that, as an early step down this road towards better engagement of patients in thinking about the health service, there may be an argument for charging for missed appointments. Such a system could deliver benefits through better efficiency in the service arising from increased patient responsibility and thus decreased levels of missed appointments.

Health promotion

- 6.90 The principal way in which the Review’s estimates have taken account of public engagement is through improved public health, as a result of better health promotion and disease prevention. In the framework set out in Box 6.1, promotion and prevention play an important role in moderating the need for care.
- 6.91 Pro-active policies which promote reductions in key risk factors and improved health information will help people to engage with their own health and make informed judgements about how to reduce their risk of ill health. Achieving the very best health outcomes will require people not only to take up the right to high quality health care, but also to take responsibility for their own health status.

- 6.92 At the same time, it will require additional resources to be directed to public health, targeted at those interventions where the long-term impact will be greatest in terms of health gain.
- 6.93 Respondents to the Interim Report expressed the need for clearer links between funding allocation and cost-effectiveness. For example, Action on Smoking and Health commented that “tobacco causes about one in three cancers and about one in seven deaths through CHD, yet the extra money is to be spent overwhelmingly on treatment, palliative care, and secondary prevention”. Professor Sir George Alberti, President of the Royal College of Physicians, noted that “smoking cessation is extraordinarily cost-effective compared to almost everything else the NHS does”.
- 6.94 In particular, interventions that successfully target population groups who currently suffer the most ill health will need to be identified and scaled up appropriately. Evidence to support such decision-making is growing and the Government’s cross-cutting review on health inequalities as part of the 2002 Spending Review is pushing this forward. The desirable health outcomes depicted in the *fully engaged* scenario are only likely to come about with a step change in the way public health is viewed, resourced and delivered nationally. This will support a future public more engaged in maintaining their health.

CONCLUSION

- 6.95 The benefits of reaching such a situation are large: significantly better health outcomes for the same or lower expenditure, as the scenarios illustrate. This is particularly important in thinking beyond the 20 year horizon. The demographic profile becomes much less favourable during the period between 2020 and 2040 as the ‘baby-boom’ cohorts reach older age, increasing pressure not only on health care but also on social care and other areas of public expenditure such as pensions. Thanks to the health outcome benefits associated with investment in public health, the UK would find itself much better placed to deal with such pressures under the *fully engaged* scenario than, say, the *slow uptake* scenario.