

Consultation Responses - Access Database Fields Required

Financing system

1) System of financing? Tax / Social Insurance / Private Insurance

Want more clarity about what is provided by NHS. Private insurance for treatment people may value but which are of no proven efficacy. Clearer separation between private insurance and NHS. Might be appropriate to ensure that private insurance covers full cost of health provision for the insured rather than just elective surgery and a few other services. This could increase share of health spending to up to 14% rather than current 4%. Don't expect this to reduce overall spending.

2) Scope for greater patient charges? No, Yes but non-clinical only, Yes include wider range

In favour of more choice and suggest charging for meals sensible.

Co-payments may encourage more cost effective use of services – could follow Swedish example. Low-level charges for beds and meals in hospital may encourage early discharge. Low level charges could also increase patient involvement in care.

Discusses concerns about two-tier nature of French system of charging for physician visits

3) Financing - general comments

Suggest that if wanted to move to social insurance could do this based on Primary Care Trusts which could become HMOs. Expect it to increase cost by 1-2%

International comparisons

4) Reasons for differences in health outcomes between UK and other countries?

Main problem for UK compared with other countries is the number of doctors. Priorities include: upgrading primary care and hospitals; reducing variations in performance within the service; tackling waiting times and greater investment in health promotion and prevention.

5) International comparisons - general comments

Page 31 of response notes that Scotland, Wales and NI level of spending per head on health is above Sweden – despite sparsity being greater in Sweden than in these countries.

Graham Lister favours comparisons based on rates of improvement in outcomes rather than levels. On absolute levels Japan, France and Switzerland do well, New Zealand, USA and UK poorest. Looking at rate of improvement over 1990s Sweden

comes out best by a long margin, UK doing quite well between 1992 and 1997 (third) ahead of Germany, France and Canada.

Overall conclusions – Swedish, French and Japanese systems are among the best in the world. In Japan rate of improvement is not as fast as other countries, in France high cost, two-tier access due to charging regime and health fund debts are downsides. Overall concludes Sweden can probably claim to be best in the world.

Changing patient and public expectations (chapter 7)

6) Consultation question 7.1

see summary in response

7) Consultation question 7.2

see summary in response

8) Consultation question 7.3

see summary in response

9) Consultation question 7.4

see summary in response

10) Expectations - general comments

Delivering high quality health care (chapter 8)

11) Consultation question 8.1

see summary in response

12) Consultation question 8.2

see summary in response

13) High quality general comments

Changing health care needs (chapter 9)

14) Consultation question 9.1

see summary in response

15) Consultation question 9.2

see summary in response

16) Consultation question 9.3

see summary in response

17) Consultation question 9.4

see summary in response

18) Consultation question 9.5

see summary in response

19) Consultation question 9.6

see summary in response

20) Consultation question 9.7

see summary in response

21) Health care needs - general comments

International comparisons of health promotion show UK is a relatively low spender (although not clear how comparable definitions are). Share of health budget:

Canada 6.2%

Japan 4%

Netherlands 3.9%

USA 4.1% (this is on public health programmes – a lot of it on bio-terrorism)

France 2.5%

Germany 2.2%

UK 1.1%

Technology and medical advance (chapter 10)

22) Consultation question 10.1

see summary in response

23) Consultation question 10.2

see summary in response

24) Consultation question 10.3

see summary in response

25) Consultation question 10.4

see summary in response

26) Consultation question 10.5

see summary in response

27) Technology - general comments

Useful fact – New chemical entities in 1980 – 70 a year by 2000 slowed to 40 a year expect it to accelerate so that by 2022 may get 200 a year

The future workforce (chapter 11)

28) Consultation question 11.1

see summary in response

29) Consultation question 11.2

see summary in response

30) Consultation question 11.3

see summary in response

31) Workforce - general comments

Health care productivity (chapters 10 and 11)

32) Consultation question 11.4

see summary in response

33) Consultation question 11.5

see summary in response

34) Consultation question 11.6

see summary in response

35) Consultation question 10.6

see summary in response

36) Productivity - general comments

Variations within the UK (chapter 12)

37) Consultation question 12.1

No comments

38) Consultation question 12.2

No comments

39) Consultation question 12.3

No comments

40) Consultation question 12.4

No comments

41) Consultation question 12.5

No comments

42) Consultation question 12.6

No comments

43) Consultation question 12.7

No comments

44) Variations - general comments

45) Useful quotes

‘The lack of primary care medical resources is likely to be the single greatest resource constraint to the improvement and modernisation of the NHS.’ P.19

46) Overall conclusions

Assuming that GDP increases by 2% p.a. on average over the next two decades, health spending will increase to 12% of GDP with average expenditure on health increasing by 4.7% per annum in real terms. If GDP growth is slower at 1.6% health spending would increase by 4.3% a year. Suggest that 4.5% a year should be central estimate. Growth is higher in first decade when catching up with European standards and slightly lower thereafter.

Cost driver -	Year 1-5	Year5-10	Year 10-15	Year 15-20
Expectations	1.7	1.7	1.7	1.7
Standards	1.67	1.67	0	0
Gen and im pop	0.25	0.25	0.25	0.25
Disadvantaged groups	0.2	0	0	0
Elderly	1	1	1	1
Technological advance	1.3	2.1	3	3.95
CIT	0.25	0.125	-0.25	-0.375
Efficiency	-1.7	-1.7	-1.5	-1.5
HP and Self Care	0.296	0.296	-0.296	-0.296
Total	4.966	5.441	3.904	4.729

47) Summary comments

Also discuss importance on policy responses to control costs and improve health. Highlight importance of:

- Delegation responsibility to local levels – Finnish health system successfully undertaken similar exercise a potentially useful case study. Note some concerns about the role of Regional performance management in this.
- More resources in primary care – main constraint on system.
- Ensuring that Commission on Patient and Public Involvement in Health develops into a really powerful national and local voice to deliver more responsive service – see this as a key way to stem calls for social insurance model.
- Targeting main drivers of ill health – most important after smoking is obesity. Also mental ill health.
- Doing more to examine health impact of economic and social policy – tackle fragmentation of public health. Improve evidence of cost-effectiveness.
- Addressing health implications of globalisation.

