



THE FUTURE OF HEALTHCARE

Introduction

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SMF HEALTHPROJECT



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1. STATEMENT OF PURPOSE

*'We shall never have all we need.
Expectations will always exceed capacity.
The service must always be changing,
growing and improving – it must always
appear inadequate.'*

Nye Bevan on the NHS¹

Demand for health services has outstripped the capacity available to meet it since the foundation of the National Health Service (NHS). Each new generation of politicians discovers this afresh – although their response is conditioned by their own particular ideological standpoint. Under the current government, significant efforts have been made to find the funding to bridge the gap between supply and demand so ably quantified by Derek Wanless.² Despite the controversy over the impact of that spending, it is hard to disagree that it has had a transformative effect on waiting lists; on the NHS estate and on the treatment of conditions for which National Service Frameworks (NSFs) have been developed.³

However, in reality, the increase in funding has only allowed the NHS to 'catch up', in Wanless' phrase, raising health spending to a level of Gross Domestic Product (GDP) similar to that of our European neighbours.⁴ The challenge now is how the NHS will 'keep up'. The generous

1 A Bevan, *Inception of the National Health Service* (NHS) (July 1948).

2 D Wanless, *Securing our Future Health: Taking a Long-Term View* (London: HMSO, 2002).

3 To date, NSFs have been developed in coronary heart disease; cancer care; paediatric intensive care; mental health; older people's services;

renal care; diabetes; long-term conditions and children's services with a NSF for Chronic Obstructive Pulmonary Disease due in 2008.

4 Wanless, op.cit.

above-inflation increases have tended to keep the question of long-term sustainability off the front page, but we can expect to again hear the claim being made that the core promise of the NHS cannot be delivered in a modern society.⁵

Our initial response should be scepticism. Claims that the NHS is fundamentally unsustainable have been made throughout its history. For example *The Cost of Health*, written in 1952, argued that the new health service would be such a drain on resources that the economy would be wrecked.⁶ By the early seventies, political and economic conditions put the NHS into a state of crisis and demoralization which the historian of the NHS, Charles Webster, suggests was worse than ever before or since.⁷ However none of the predictions of the NHS' incipient demise have been borne out. Nor would the NHS' founding father, Nye Bevan, have been surprised by these debates. As the epigram to this paper shows, he foresaw that there would always be a mismatch between what the public would want from a national health service, and what that service would be able to deliver.

The reasons people gave as early as the 1950s for assuming that the NHS could not be sustained sound remarkably familiar to modern ears. Rising public expectations of the standard of service were a concern, as were the cost of advances in medical technologies and medicines. In each instance, the NHS adapted to survive while maintaining support from the British population. For example funding was bolstered by the introduction of dental and prescription charges as early as 1952.⁸ It is not obvious that the situation in 2007 is in some way fundamentally different – that adaptations cannot be made that allow us to retain an NHS

5 For example see British Medical Association

6 F Roberts, *The Cost of Health* (London: Turnstile, 1952).

7 C Webster, *The National Health Service: A Political History* (Oxford: OUP, 2002), pp. 138-139.

8 The Amending Act 1949 allowed for the introduction of prescription charges. On 1 June 1952, charges were introduced for the first time and continued until their abolition on 1 February 1965. Prescription charges were reinstated in 10 June 1968.

paid for out of taxation, free to use and available according to need. The primary focus of this project will therefore not be how to address ‘a funding crisis’ or to meet ‘the funding gap’. Instead we will examine the broad range of ways in which the NHS might adapt to meet future demand whether that be through additional sources of funding, demand management measures or reforms to how services are delivered. The objective of the research is to answer the following fundamental question:

‘In what ways does the NHS need to adapt in order to meet the population’s demands for healthcare over the next fifteen years?’

As part of our work we will of course draw on the expert work that has been carried out estimating future funding needs for healthcare and will examine the range of options open to government to raise funding from alternative sources including user charges.⁹

But we will also look at the scope that exists for improving productivity within the NHS both through the way in which the health professions carry out their roles but also through better use being made of facilities and stock. It is important to note that any successful reforms in this area would need to be carried out not just with the consent of the NHS workforce, but with its active collaboration. It is also clear however that as deference for authority recedes, and patient knowledge and information advances, the relationship between professionals and patients will need to be renegotiated.

⁹ For example: Wanless, *op.cit.*; E Bramley-Harker and T Booer, *Mind the Gap: Sustaining Improvements in the NHS Beyond 2008* (BUPA, 2006).

We will also look for ways in which the efficiency of the service can be improved. Although politically very challenging, a key element of this will be reconfiguration of services. This has the capacity to deliver real efficiency gains for the NHS, not least through the devolution of some forms of diagnostics and treatments to primary care level. The introduction of practice-based commissioning should help facilitate this.

We should not assume that better-informed patients will correlate directly with greater burdens on the NHS. Although rising patient expectations may well increase demand, it is important that we also acknowledge the scope for better health outcomes. For example, changing the doctor-patient dynamic opens up the opportunity for a greater emphasis on self-directed care which has the potential to reduce demand for services through better health management.

The project's final report, due in 2009, will provide a set of recommendations for government covering all of these issues: funding; productivity; efficiency and demand management. In doing so, it will establish a road map for current and future governments to maintain the core promise of our National Health Service.

2. ABOUT THE PROJECT

The Future of Healthcare will run for just over two years between January 2007 and early 2009 and will include a major programme of research and events. The project will have three stages. First, we will make robust predictions concerning the likely trends and developments in UK healthcare (including patient demographics) over the next fifteen years. Second, we will analyse the likely impact of those developments on the NHS and other providers. Third, we will develop a set of recommended changes to the provision of health services such that the NHS might cope better with the inevitable new challenges that will arise.

We will hold a series of seminars and discussions during the course of the project, and publish a number of discussion papers for comment. We would encourage all interested parties who wish to have an input to get in touch – contact details are given below.

There are two groups in particular whom we are keen to involve in the project. The first is health workers. The medical professions have a great deal of underused expert knowledge about the scope for better health outcomes through improvements in productivity and efficiency and this is a resource we are keen to draw on. Policy-makers have sometimes neglected to engage fully with NHS staff when developing reforms and, while they should not have an absolute veto on potential developments, it is very important that they are treated as partners in a collective effort to improve health outcomes.

The second group we are keen to involve is the general public. The project will include quantitative and qualitative research on public attitudes to critical issues, including rationing mechanisms and local diversity in provision. We will also use deliberative fora to allow for broad debate of the options for reform. Overall our aim is to foster an

informed public debate about the options for the future of healthcare in the UK. For although, in general, there is strong public support for the NHS, it is not matched by a clear understanding of the decision-making processes involved, particularly in relation to access to medicines and treatments.

3. PROJECT SCOPE

Divisions between the provision of health and other services are not always clear-cut, particularly in relation to social care. This is as it should be - we believe strongly that the patient or client experience of the NHS and social services should be seamless and that funding barriers between the two services should be broken down. However, the future of social care in the UK is a major question in its own right. Given this, our project will be limited to the provision of health services although it will make reference to social care when necessary. This is particularly important given the close relationship between demand for social care and demand for healthcare and therefore between funding requirements for the two services.

The National Health Service has sometimes been referred to as a national sickness service because of an insufficient focus on preventative care. This criticism is justified from a historical perspective although there have been welcome shifts towards a greater focus on public health in the last five years. That said, the factors influencing public health go far beyond the provision of health services to the work of schools and colleges; the food industry; the market for illegal drugs and the design of our towns and cities. We have therefore chosen to limit our focus to health services rather than public health although we will be considering the balance between preventative and other services.

Overall our aim is to foster an informed public debate about the options for the future of healthcare in the UK.

The development of different models for the health services in England, Wales and Scotland provides for a fascinating exercise in comparative analysis. However that again is a project in its own right and beyond our scope here. The project will therefore focus on the English health service although we will draw lessons from comparisons between the three countries for our conclusions.

One way in which our remit will be broad is by including in our analysis the full range of providers of health services in the UK, including the private, not-for-profit and voluntary sectors. Hence the scope of project will cover all healthcare providers in England.

4. QUESTIONS FOR THE RESEARCH

1. What will the impact of demographic changes be?

The research will examine predicted changes to the demography of England over the next 15 years, and we will consider the likely impact of these changes on the NHS and other providers. Of particular interest will be the increasing average age of persons in England. Does this place new burdens on the National Health Service, or can we expect costs to still be compressed into the last two years of a person's life (irrespective of how long they live)? A recent study in the *British Medical Journal* predicted a 53% rise in the number of people in the UK aged 65 and over between the years 2001 and 2031. Taking just three common diseases (coronary heart disease, heart failure, and atrial fibrillation), the study predicted rises in incidence rates of 44%, 54%, and 46% respectively.¹⁰ The changing burden of disease will also have implications for the NHS drugs bill. With more patients living with long term cardio-

¹⁰ A Majeed and P Aylin, 'The Ageing population of the United Kingdom and cardiovascular disease' (*British Medical Journal*, 331: 2005), p.1362.

vascular problems pharmaceuticals such as statins, which are prescribed to patients with an elevated risk of heart attacks, will be more widely consumed. While some popular statins will be coming off patent and reducing in cost, the likely shift in resources away from acute care and towards preventative treatment may still have significant cost implications for the NHS.

Of further interest will be the increasing disparity in the UK between the numbers of retired (non-tax paying) and non-retired (tax-paying) persons. The 2001 Census of Britain showed that for the first time there are more people aged over 60 than under 16, and also showed a 500% increase in the number of over 85s (to 1.1 million) since the census of 1951.¹¹ What impact might these demographic changes have on the funding of the NHS: is there likely to be a serious mismatch between 'net contributors' to the NHS (younger, healthier, tax payers) and 'net consumers' (older, less healthy, non-tax payers)?

2. What will the impact of medical, pharmaceutical and ICT advances be?

What pressures is the NHS likely to face in the short and medium term as a result of the continued advancement of medical technology (with the inevitable associated increase in the number of effective treatments)? In particular, when can we expect refinements of genetic technology to yield significant new treatments and diagnostic tests? Genetic technology offers several exciting – but costly – possibilities. First, there is the prospect of increasingly sensitive diagnostic tests. As well as the expense of these tests themselves, they are likely to cause higher downstream costs: many patients currently diagnosed 'too

¹¹ UK 2001 Census. Available at <<http://www.statistics.gov.uk/census2001/census2001.asp>> [30 July 2006].

late' (i.e. those for whom the natural history of their disease cannot be treated) will be diagnosed 'in time' and will be candidates for treatment. Second, there are genetic treatments. A vast range of conditions considered to have strong genetic components in their aetiology – many cancers, some forms of heart disease, many developmental disorders – are likely candidates for the development of various forms of genetic treatments. These treatments are likely to come to market with hefty price tags, since they will represent the culmination of vast research and development programmes.

Is the existing statutory body charged with the assessment of new technologies – the National Institute for Health and Clinical Excellence (NICE) – sufficiently well-equipped for the new challenges it will face? Although it is being looked at with interest by a number of other governments, the core of NICE's work – the so-called 'technology appraisal process' is still relatively undeveloped. To date, NICE has conducted a relatively small number of these appraisals. This combined with the relatively slow pace at which NICE can turn around an appraisal, from constructing the initial scope to producing the 'final appraisal determination', suggests that NICE is currently struggling with what is already a demanding workload.¹² The advancement of medical technology is likely to ensure that this workload increases in the near future. How can we ensure that NICE will be up to the task?

Leaving aside its size and capabilities, the precise methodology adopted by NICE is likely to come under closer scrutiny the more it has to make 'tough choices' concerning potentially exciting (but costly) new treatments. Currently, NICE operates a 'cost-effectiveness' methodol-

¹² Concerns about the relatively slow pace at which NICE operates has led the current government to state explicitly that the absence of any NICE guidance on the suitability or otherwise of drugs for provision on the NHS does not constitute sufficient reason for a Primary Care Trust not to fund that drug. In situations where no NICE guidance yet exists,

an 'interim' procedure must be adopted: PCTs are expected to appraise the best existing evidence themselves in arriving at their own funding decision.

ogy, where it attempts to extract the maximum amount of benefit from available NHS resources. Rather than ranking treatments for relative cost-effectiveness, NICE is believed to operate a threshold system, where treatments that fall on the 'wrong' side of the threshold (currently believed to lie somewhere between £25,000 to £35,000 per quality adjusted life year gained) are not considered candidates for public funding.¹³ However, even if we accept a threshold methodology rather than a relative ranking methodology, it is unclear how this *particular* threshold has been justified (if indeed it has). Justifying the threshold will require more open debate, about more substantive ethical issues, than NICE has so far been willing to engage in. The recent attempt by NICE to incorporate what it calls 'social value judgements' is widely considered to be ineffective.¹⁴ It is unlikely that increasing public expectations about what the NHS can deliver will be effectively managed until some way is found to include public views about how to rank the importance of different kinds of medical benefits within the context of relative resource scarcity.

3. How will changing public expectations alter demand for health services?

The increased focus on patient choice and personalisation; the growth of new treatments and more readily available public information will undoubtedly lead to changes in public expectations of the NHS and other providers. Exactly how are these expectations likely to change over the short and medium terms? Which of these expectations could be considered 'healthy' (and ought perhaps to be encouraged)? How do we communicate information to patients in such a fashion as to ensure that they make, and keep making, informed choices about their health-

¹³ Or so said the Chairman of NICE in the *Economist* (*Economist* [2006] 25th February 'Inescapable trade-offs').

¹⁴ J McMillan et al., 'Ethics and opportunity costs: have NICE grasped the ethics of priority setting?' (*Journal of Medical Ethics*, 32: 2006), p. 127-128.

care? How do we ensure this information is communicated effectively to patients of different ethnic groups and socio-economic classes? A report by The Commission for Health Improvement (now the Healthcare Commission) found that around 75% of patients in some PCTs felt they did not receive adequate information about local health providers, (including, crucially, about GP practices). The report also found that information was unevenly spread across ethnic groups, with minority ethnic groups faring worst (due in no small part to the poor quality of translation facilities).¹⁵

Conversely, what kinds of expectations (if any) ought to be considered 'unhealthy'? Are drives towards choice and personalisation in health-care likely to lead patients to demand certain things from the health-care system that they ought perhaps not to expect? What are the cost implications of 'unhealthy' expectations? How might these expectations be managed?

As patients become more informed about the range of treatments available, how will the relationship between patients and medical professionals evolve? Will a greater degree of knowledge by patients be translated into a greater degree of personal responsibility for healthcare? Given the effectiveness of self-care in terms of outcomes, and the cost-effectiveness of such approaches, can renegotiation of the patient-doctor relationship encourage greater self-care and personal responsibility?

15 Commission for Health Improvement, *What CHI has found in: primary care trusts* (London: Commission for Health Improvement, 2004) <http://www.healthcarecommission.org.uk/_db/_documents/04001441.pdf>. For a fuller discussion of information provision to patients, with special reference to NHS primary care, see: P Corrigan, *Registering*

Choice: how primary care should change to meet patient needs (London: Social Market Foundation, 2006).

As patients become more **informed** about the range of treatments available, how will the **relationship** between patients and medical professionals evolve?

4. Will the NHS reform programme result in better health outcomes and / or efficiency gains?

The NHS has undergone an extensive reform programme since 1997, particularly since the publication of the NHS Plan, with perhaps the two most significant structural changes being the introduction of certain forms of patient choice, and the ‘payment by results’ system of financing.¹⁶ There are many ways in which it might be possible to measure the success of these reforms; we might, for example, focus on the effects they have had on levels of patient satisfaction.

Important though markers such as patient satisfaction are, it is widely hoped that these two structural changes will bring benefits of a more fundamental kind: significant efficiency gains across many of the working practices of the NHS, both with regard to the driving down of costs and the levering up of quality levels. The SMF has already undertaken extensive analysis of the international evidence concerning the possible efficiency gains that can be wrought by choice of service providers.¹⁷ Crucially, that evidence showed that only choice systems marked by certain features were likely to produce efficiency gains. These features included: the provision of a good range of desirable choices; the information required to make these choices appropriately; autonomy for providers to respond to the expressed preferences of service users; direct financial consequences for providers who respond or fail to respond to choices; having well-functioning systems to prevent providers ‘cream-skimming’ the ‘best’ service users; and having a well-functioning system in place to deal with failing providers.

If these are the kinds of features that choice systems must possess in

¹⁶ *NHS Plan: A plan for investment; a plan for reform* (London: HMSO, July 2000).

¹⁷ J Williams and A Rossiter, *Choice: The Evidence* (London: Social Market Foundation, 2004).

order to bring about efficiency gains, can we look to the recent structural changes made to the NHS and predict the likely arrival of these gains? We should consider whether patients are being presented with a good range of choices, with regard to times, places, and treatments and whether this range of choices is enjoyed by patients in all parts of the country, or just by those living in urban areas. We should also consider whether providers enjoy requisite degrees of autonomy, and whether 'payment by results' expose them directly to both the positive and negative consequences of responding and failing to respond to patient choices. A key question is whether these consequences are being felt keenly enough by 'coasting' providers? Are NHS goods and services currently being costed in a way that levies powerful enough incentives on providers to work efficiently? To evaluate whether the system will prove equitable we also need to ask whether the 'cream-skimming' of certain kinds of patient takes place and whether adequate failure strategies are in place to deal with providers currently performing poorly under choice arrangements. How can these strategies aid failing providers without thereby blunting the system's overall incentive structure?

Another major element of reform is a significant reconfiguration of services, to take account of modern medical practice and changing local populations. In some cases this will lead to the closure of facilities and the loss of certain services by local communities. As such, it presents a significant national and local political challenge. To what degree will local opposition force the retention of inefficient and even inferior quality local services? What will the impact of such a development be on the quality and efficiency of the NHS overall? Some ministers have floated the idea of an independent Board for the NHS which would take responsibility for such decisions out of the hands of politicians. Would devolving responsibility to an independent authority allow for more rational and effective decision-making on these and other issues?

5. Will reform of the primary care sector improve health outcomes?

It is difficult to overstate the importance of primary care within the NHS: more than 80% of all treatment episodes begin and end in primary care. Given its importance, and also given the fact that primary care has a good claim to be the most ‘reformed’ part of the NHS, we will analyse separately the impact of recent primary care reforms. We expect to focus on two trends that might seem to pull in opposite directions.

The first trend concerns the average size of Primary Care Trusts (PCTs): this has been increasing steadily as more and more of these organisations merge with one another. What effect will this increase in size have on the working practices of PCTs, particularly on their key role of commissioning services? Some have argued that pre-merger PCTs (which had an average size of around 100,000 patients¹⁸) were too small to commission effectively – the amounts of goods and services commissioned were insufficient to pose a serious ‘threat’ to providers were contracts to be terminated. However, some others feel that overly large PCTs are unlikely to commission appropriately and sensitively for the

18 C Bojke, H Gravelle, and D Wilkin, ‘Is bigger better for primary care groups and trusts?’ (*British Medical Journal*, 322: 2001), p. 599-602. These authors present evidence suggesting that the per capita cost of providing healthcare is minimised with patient populations no larger than 100,000, and that managerial economies of scale are exhausted at levels much smaller than 100,000. There

is, however, countervailing evidence from the USA suggesting that mergers between health maintenance organisations which take the combined served populations to much more than 100,000 can create new economies of scale that in turn can lever cost reductions. R Town, ‘The Welfare Impact of HMO Mergers’ (*Journal of Health Economics* 20: 2001), p. 967-990).

patient populations they serve, and risk becoming as remote and unresponsive to local needs as were their predecessors, the old health authorities.¹⁹

If PCTs are to become more effective commissioners while retaining the ability to respond sensitively to local needs, several possible reforms might be necessary. First, it might be important to relax the number of centrally-determined priorities to which PCTs are expected to respond: it has been argued that being overburdened with these kinds of priorities 'can seriously impair capacity for local action.'²⁰ Second, PCTs will have to become far more efficient at gathering and using the information required to commission effectively. Recent reports by both the Healthcare Commission and the Audit Commission have revealed that many PCTs are still underperforming in this key area.²¹ Third, greater responsibility might have to be assumed by the Professional Executive Committees within PCTs. High hopes have been expressed for these bodies as being the key to ensuring sensitive commissioning for defined local populations, but concerns remain that they have yet to realise their full potential.²²

However, it is the second of the two trends we propose to focus on that perhaps offers the greatest hope for ensuring that the particular health needs of local populations are met in a sensitive fashion. This is the drive to devolve at least some amount of commissioning power away from PCTs and towards GP practices, under the so-called 'GP practice based commissioning scheme'. The Department of Health hopes this

19 W Anderson, D Florin, S Gillam, and L Mountford, *Every Voice Counts: Primary Care Organisations and Public Involvement* (London: King's Fund, 2002).

20 J Banks-Smith, C Shipman, and S Gillam, 'What Influence have national service frameworks had on the priorities of primary care groups and trusts?' (*The Journal of Clinical Governance*, 10: 2002), p. 7-11.

21 Commission for Health Improvement, *What CHI has found in: primary care trusts* (London: Commission for Health Improvement, 2004); Audit Commission, *Transforming primary care: The role of primary care trusts in shaping and supporting general practice* (London: Audit Commission, 2004).

22 S Feast, *Clinicians: Managing to Lead* (Health Director Magazine, January 2003).

scheme will 'secure a wider range of services, more responsive to patient needs and from which patients can choose.'²³ Over time, it is hoped that GP practices will take over the bulk of commissioning work currently undertaken by PCTs. Such a shift is likely to take time, and in the interim period it is expected that many GP practices will ask PCTs to 'commission particular services on their behalf'.²⁴ Even when practice based commissioning is fully mature, it remains likely that certain very costly and complex services – such as organ transplants – will remain exclusively commissioned by PCTs.

In short, with the introduction of practice based commissioning the Department of Health hopes that there will be a plurality of commissioners within the NHS: individual GP practices, groups of GP practices who come together specifically to form commissioning groups, and PCTs.²⁵ The initiative might provide for more sensitive forms of commissioning, but only if certain preconditions are met.

First, it is important that any move towards a plurality of commissioning bodies is marked by mutual understanding between these bodies with regard to their respective roles. How likely is this to transpire? The signs are perhaps discouraging: both the CHI and Audit Commission reports into PCT commissioning mentioned above highlighted confusion within PCTs regarding respective roles when PCTs commission on behalf of each other or in conjunction with local authorities. Perhaps most worryingly, the Audit Commission report argued that PCTs must seek to improve their understanding of the different kinds of resources available to GP practices and the various ways in which these resources are used.²⁶

23 Department of Health, *Practice Based Commissioning: Engaging Practices in Commissioning* (London: Department of Health, 2004).

24 Ibid.

25 Ibid.

26 Commission for Health Improvement, *What CHI has found in: primary care trusts* (London: Commission for Health Improvement, 2004); Audit Commission, *Transforming primary care: The role of primary care trusts in shaping and supporting general practice* (London: Audit Commission, 2004).

Second, it is important that sufficient numbers of GP practices are incentivised to participate in the practice based commissioning initiative. One possibly important set of means for doing so are broadly financial in nature. There is some evidence to suggest that participation in the GP Fundholding scheme put in place by the previous government was at least partly motivated for many practices by the prospect of making a budgetary surplus which would be retained by that particular practice.²⁷ However, it is not clear whether GP practices would be allowed to retain any surpluses they might generate under the new practice based commissioning scheme. Guidance from the Department of Health states that 'resources freed up from effective commissioning must be used for developing or providing services for patients'. The Department is clear that 'resources must not be used for individual profit', and encourages 'practices to consider pooling resources to invest in projects that will benefit all the PCT's population and not just their own patients'.²⁸ While this kind of pooling might have well-intentioned equitable concerns behind it, there is a danger that there will be insufficient financial incentives for GP practices to take on commissioning roles if they know that the cash benefits of any efficiency gains they might make will be distributed throughout the PCT population.

6. How should the NHS deal with poorly performing providers?

As the SMF's previous empirical work on choice of provider systems has pointed out, only systems that allow funds to flow directly to well-functioning areas (where services users are choosing to go) are likely to bring about efficiency gains. Allowing funds to flow in this way will mean that unpopular providers will become starved of resources, and are likely to see their performance levels drop still further. The practi-

²⁷ T Gosden and DJ Torgeson, 'The effect of fundholding on prescribing and referral costs: A review of the evidence' (*Health Policy*, 40: 1997), p. 2.

²⁸ Department of Health, *Practice Based Commissioning: Promoting clinical engagement* (London: The Stationery Office, 2004).

cal and political difficulties that would ensue were we just to let these poorly performing providers collapse are very great, and many believe that choice systems ought to be supplemented with ‘failure strategies’ to assist struggling providers.

The financial disparities between well functioning and poorly functioning areas of the NHS are likely to grow even wider with the anticipated funding slowdown from 2008 onwards. The pressure on those providers currently struggling under the patient choice and payment by results initiatives is likely to increase. This poses the important question: exactly what kinds of failure strategies are appropriate for the reformed NHS? Crucially, how can these strategies be designed such as to provide timely and appropriate assistance to struggling providers, without at the same time blunting the new set of financial incentives within the NHS?

7. How can the impact of the anticipated funding slowdown be mitigated?

The extensive reforms recently undertaken in the NHS have been accomplished at a time when unprecedented levels of resources have

been injected into the system. However, it is widely anticipated that the level of investment in the NHS will begin to tail off in 2008.

This means that reformed NHS structures, very much 'children' of the massive increase in funding, will have to bed in and consolidate in a quite different financial climate. How successful might they be in achieving this? Patient choice, in particular, requires the provision of a good range of alternatives to patients, if the system is to bring about efficiency gains: will the range and quality of options open to patients be adversely affected by the funding slowdown? Similarly, payment by results requires an extensive, accurate, and ongoing regime of costing NHS goods and services through the national tariff. The government is also expected to extend the reach of the national tariff beyond secondary acute services into other areas such as community care.²⁹ This will in turn require substantial and continued investment – can we expect this investment to be maintained after 2008? Finally, as we have suggested above, providers currently struggling under the new NHS reforms are likely to fare even worse when the funding slowdown begins to bite, making it all the more important that well-functioning failure strategies are in place by this time.

When the impact of the funding slowdown is combined with the previously described changes to the demography of the UK, the heightened public expectations of the NHS, and the appearance of new forms of medical technology, it is easy to see the importance of investigating additional revenue streams for the NHS over and above general taxation (which is likely to remain the single largest funding source for the foreseeable future). One important area for further research is extending

²⁹ Hansard 5 Dec 2006 : Column 390W.

Increasing revenue is only one way of dealing with the funding slowdown: of equal importance will be measures taken to control costs.

the use of forms of co-payment within the NHS. Any such extension has to be very carefully handled, however. A sufficiently sensitive exemption scheme must be in place to ensure that we are not deterring those from lower socio-economic groups from seeking treatments. Not only would this be inequitable since these groups are frequently poorly served already by many areas of the NHS, it also likely to be economically counterproductive (as higher 'downstream' costs are likely to accrue when many of these individuals become more seriously ill as a result of not seeking treatment). In addition, the administration costs of any expanded co-payment scheme must be carefully costed to ensure that any gains in revenue are not swallowed up by new forms of expenditure.

Increasing revenue is only one way of dealing with the funding slow-down: of equal importance will be measures taken to control costs. Again, forms of co-payment might be useful in reducing one kind of unnecessary cost: usage of services by the 'worried well'. In practice, however, it will be very difficult to design co-payment systems sufficiently sensitive to deter only this group of patients from using services improperly. Of potentially greater use are forms of preventative medicine that might, if used properly, bring about considerable cost savings for the NHS. The cost effectiveness of these forms of healthcare has rarely been adequately assessed. Of particular interest might be initiatives to encourage the public to take greater control over their own health – bringing about a shift to the more 'engaged' scenarios envisaged in the first Wanless Report of 2002, and which were considered important for the continued financial viability of the NHS.³⁰

³⁰ Wanless, *op. cit.*

8. What potential exists for productivity gains?

There is little reliable information available on public sector productivity, and many measurement techniques are best described as experimental. The publication of the Atkinson Review in 2005 helped in the process of developing a consensus around measurement and recommended major improvements in the measurement of outputs across the public services.³¹ However authoritative measures are still lacking. This relative ignorance is mirrored in our lack of understanding of the key determinants of public sector productivity compared to the state of knowledge on productivity in the private sector, although work is being conducted in this area by the London School of Economics and others.³² This is a highly significant issue for the NHS as even low levels of improvements in health service productivity would have a significant impact on the level of funding required by the NHS.

The Government has developed a four-point framework to encourage productivity in public services which can be summarised as (a) the development of goals expressed as desired outcomes; (b) greater discretion for local service providers alongside effective governance structures; (c) improved information about performance; and (d) better incentives for service providers to meet users' needs.

We will ask how relevant this framework is to the improvement of health services' productivity, and pose the question: what does the latest research tell us about key determinants. What impact do the controversial areas of contestability in service delivery and employee incentives have on public service productivity if any? What can be learned from looking at productivity in the commercial provision of health services?

31 T Atkinson, *Atkinson Review of Government Output and Productivity for the National Accounts: Final Report* (London: HMSO, 2005).

http://cep.lse.ac.uk/research/innovation/public_sector.asp.

32 The Governance, Leadership and Public Sector Performance Initiative, Centre for Economic Performance, London School of Economics

5. PROJECT GOVERNANCE

The project is managed by Ann Rossiter, Director, and Natalie Tarry, Director of Research at the SMF. The project also has a Steering Group, composed of some of the best-informed and most acute commentators on health policy in the UK. They have generously agreed to give their time to provide the SMF with advice, guidance and feedback in the conduct of the project. Their involvement in no way suggests that they agree either with the aims or conclusions of the project, or indeed with each other. In fact one of their objectives is to be dissenting and challenging voices.

They are:

- **Mark Britnell**, Chief Executive of the South Central Strategic Health Authority, NHS
- **Dr David Colin-Thomé**, National Clinical Director for Primary Care, Department of Health
- **Professor Angela Coulter**, Chief Executive, Picker Institute
- **Nigel Edwards**, Director of Policy, NHS Confederation

- **Chris Exeter**, Head of Public Policy, Office of the Director-General for NHS IT, Department of Health/NHS Connecting for Health
- **Michael Hall**, Chief Executive, Standard Life Healthcare
- **Fergus Kee**, Managing Director, BUPA Health Insurance
- **Professor Julian Le Grand**, Richard Titmuss Professor of Social Policy, LSE
- **Katherine Murphy**, Director of Communications, Patients Association
- **Ben Page**, Managing Director, Ipsos Mori
- **Owen Smith**, Head of Government Affairs, Pfizer
- **Professor Peter Smith**, Professor of Health Economics, University of York
- **Nick Timmins**, Public Policy Editor, FT

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6. ABOUT THE SOCIAL MARKET FOUNDATION

The Social Market Foundation is an independent, cross-party think tank. Since its inception in 1989, the SMF has gained an enviable reputation for the rigour of its research, driving policy debate based on sound argument and clear evidence. The SMF has established a strong track record in successfully carrying out large and challenging research projects, winning research tenders from a range of government bodies, charitable trusts and private sector organisations. Crucially these projects have had a demonstrable impact on the development of policy in many areas, with the SMF widely regarded as a key influence in public policy circles.

Recent SMF health publications:

Paul Corrigan, *Registering Choice: how primary care should change to meet patient needs* (SMF, January 2006).

The SMF Health Commission (3), *Choice and Contestability in Primary Care* (SMF, February 2005).

Rt. Hon Dr John Reid MP, *Limits of the Market, Constraints of the State: the public good and the NHS* (SMF, January 2005).

Jessica Asato (Ed), *Professionally-led regulation in healthcare – just a cosy club?* (SMF, December 2004).

Jonathan Williams and Ann Rossiter (Eds), *Choice: The Evidence* (SMF, December 2004).

The SMF Health Commission (2B), *Introducing Social Insurance to the UK* (SMF, December 2004).

Jessica Asato (Ed), *Whose responsibility is it anyway? Perspectives on public health, the state and the individual* (SMF, November 2004).

Ann Rossiter (Ed), *The Future of the Private Finance Initiative* (SMF, November 2004).

The SMF Health Commission (2C), *Defining a Core Package for the NHS* (SMF, July 2004).

The SMF Health Commission (2A), *Private Payment for Health: Boon or Bane?* (SMF, January 2004).

The SMF Health Commission (1), *A fairer prescription for NHS charges* (SMF, June 2003).

7. CONTACTING THE HEALTH PROJECT TEAM

Over the course of our work we intend to seek views and expertise from many different stakeholders ranging from representatives of patient groups; NHS staff; NHS management; private and not-for-profit providers; academics; policy experts; politicians and other decision-makers. The research team will be making contact directly with many organisations but we would also welcome unsolicited contributions. Please contact Ann Rossiter at arossiter@smf.co.uk or David Furness, Project Leader, at health.project@smf.co.uk. We look forward to hearing from you.

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