Our future health secured?

A REVIEW OF NHS FUNDING AND PERFORMANCE SINCE 2002

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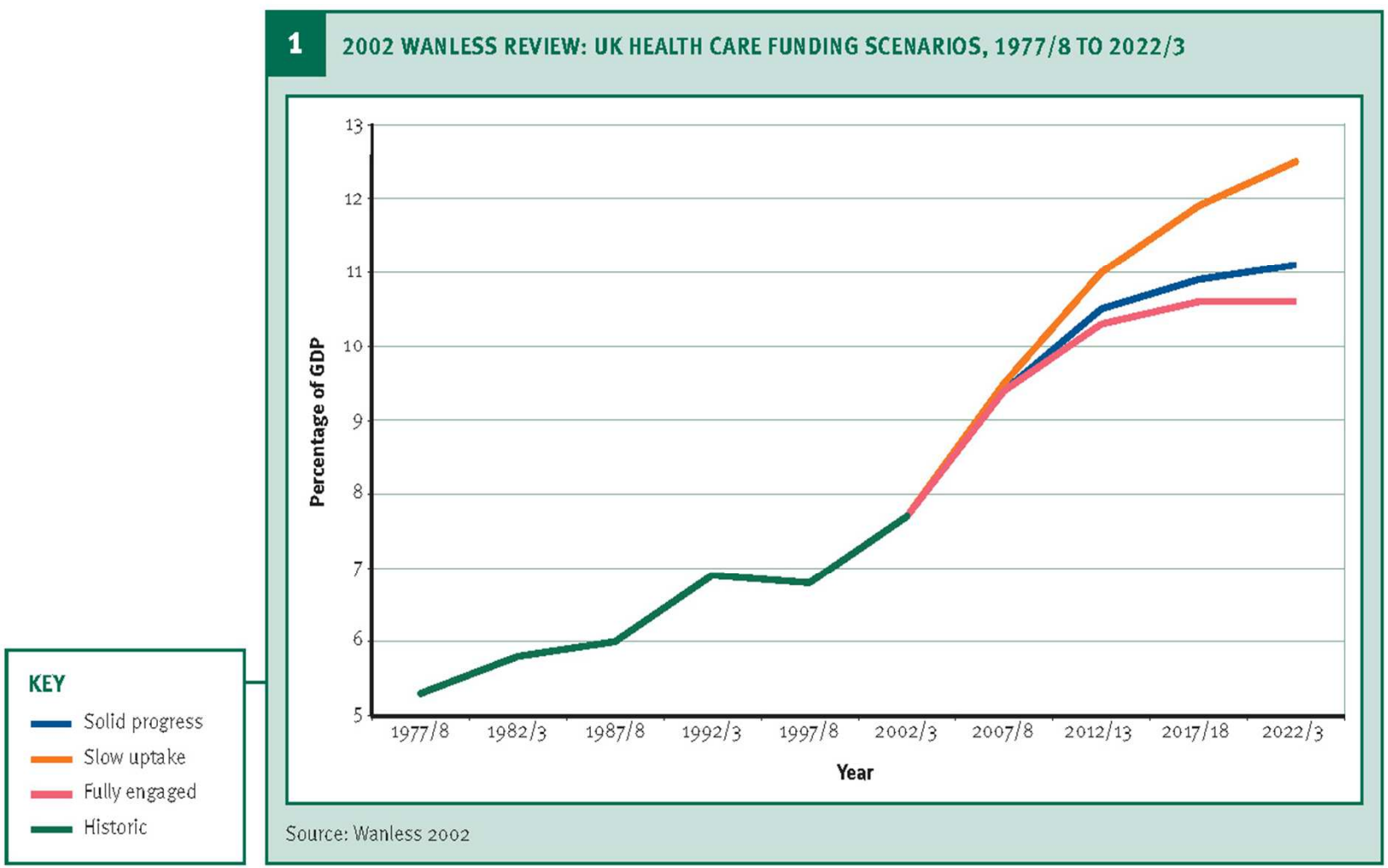
Introduction

- Five years since publication of *Securing our Future Health: Taking a Long Term View* and three years since its companion review, '*Securing Good Health for the Whole population*.
- Since then the NHS across the UK – and particularly in England – has seen a massive rise in spending.
- Five years on there are the inevitable questions:
  - How has the extra money been spent?
  - What has the NHS achieved?
  - Has government policy promoted effective use of resources?
  - What lessons have been learned for the future?
- These are the important issues addressed by this current review

The 2002 Review

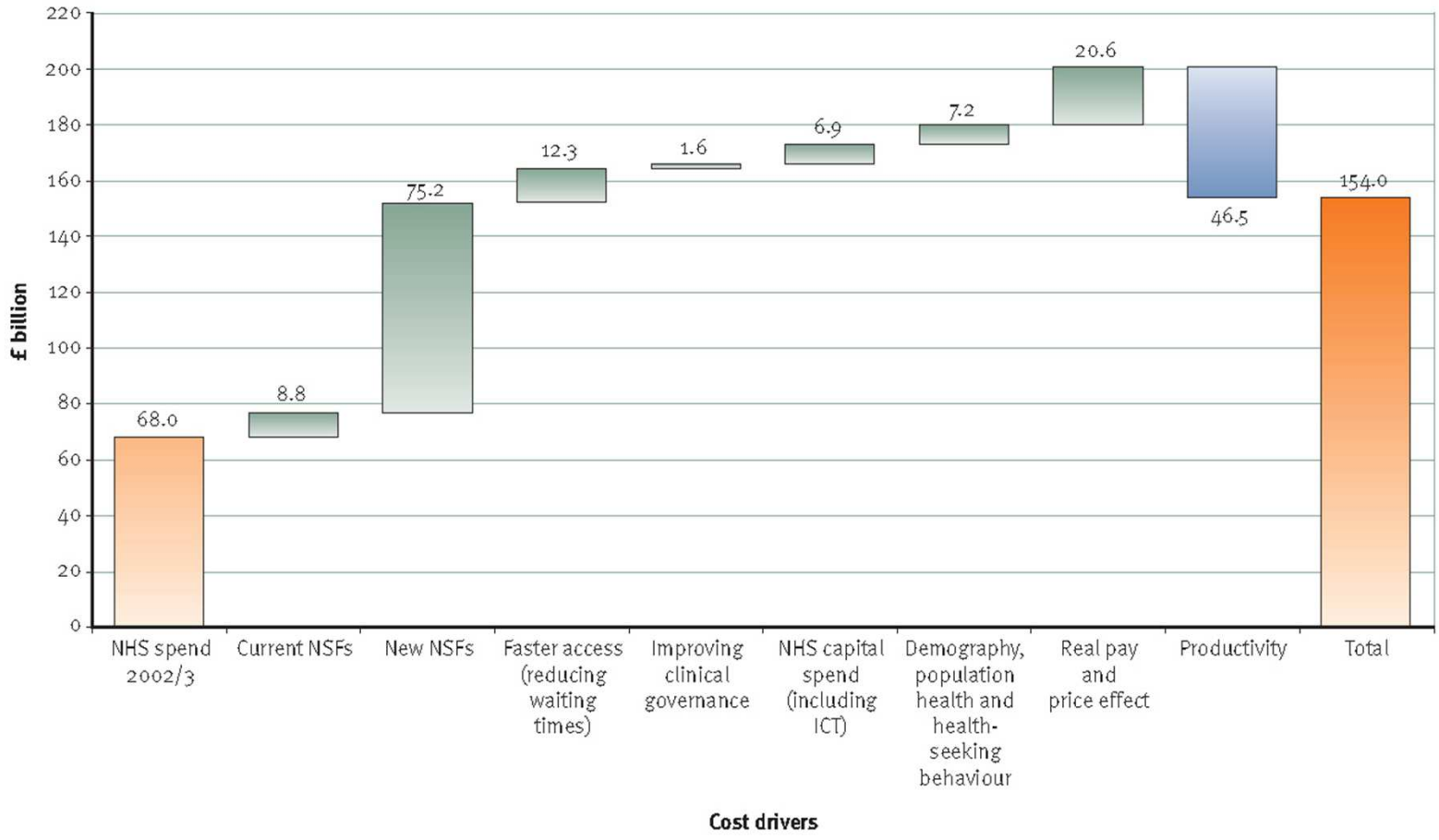
- Key recommendations:
- More money for the NHS...but coupled with reform to encourage effective use of resources
- Three scenarios of the future reflecting:
  - commitments already made to improve the quality of the health service and its consistency in the *NHS Plan* and the National Service Frameworks
  - changing patient and public expectations
  - advances in medical technologies
  - changing health needs of the population
  - prices for health services resources, including skilled staff
  - productivity improvement that might be achieved.

1 **2002 WANLESS REVIEW: UK HEALTH CARE FUNDING SCENARIOS, 1977/8 TO 2022/3**



Source: Wanless 2002

4 2002 WANLESS REVIEW: IMPACT OF COST DRIVERS UNDER FULLY ENGAGED SCENARIO FOR FIRST 20 YEARS, 2002/3 TO 2022/3



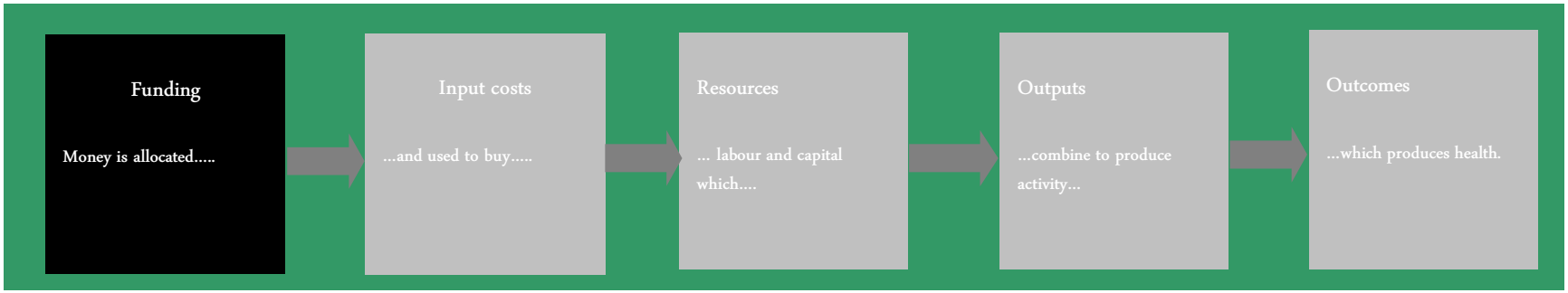
Source: King's Fund analysis; Wanless 2002

2004 Review

- Recommended a framework to aid policy formulation and practical implementation.
- Criticised the way in which targets had been set for key determinants of health, both for the whole population and for important sub-groups.
- Quantified national objectives for all the important determinants of health status needed to aid future resource planning as well as immediate decision-making. Government recommended to seek advice about what those objectives should be, paying particular attention to those key to reducing health inequalities.
- Tackle gaps in activity between the various bodies with a public health role.
- Create an adequate workforce capacity, with appropriately broad and changing skill mixes, and with self-care, 'expert patients' and community pharmacists identified as potential improvers of productivity.
- Establish evidence for the pros and cons of a radical change in primary care.
- The overall conclusion of the review was that the activity under way could put England (the nation studied) on course for the solid progress scenario as far as public health was concerned, but a step change would be needed to move to a fully engaged path.

2007 Review: Aims

- **Funding** Did health care resources increase in line with the recommendations of the 2002 review, and what are the prospects for funding up to 2022/3?
- **Use of resources** Where did the money go, and what has been achieved for the additional NHS investment in terms of resource inputs, outputs and, most crucially, outcomes?
- **Effectiveness** Have the additional resources allocated to the NHS been used effectively and in line with the 2002 review's observations about standard-setting, processes and delivery in the NHS? If not, why not?
- **Policy framework** What have the major decisions taken in these areas since 2002 sought to achieve? What have been the positive effects, the negative impacts and the unintended consequences? Have these decisions produced health and public health systems that put us on track for an optimistic future?
- **Future reviews** What lessons can be learned from this analysis of the actions taken since 2002 to inform similar reviews in future?



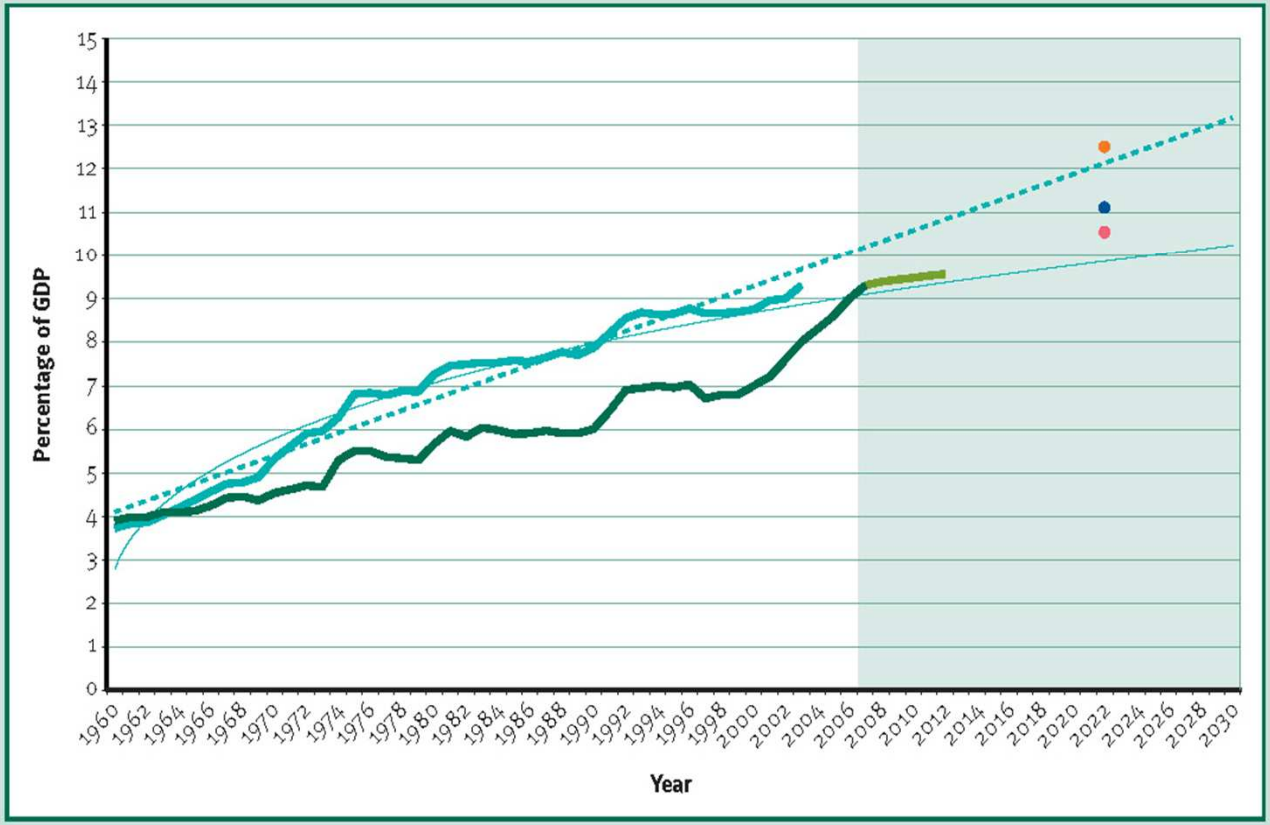
The 2002 budget confirmed that the NHS would receive an average annual real increase in funding of 7.4 per cent over the five years to 2007/8, compared with the review's recommendation of between 7.1 and 7.3 per cent.

NHS spending in the UK between 2002/3 and 2007/8 has broadly increased in line with the 2002 review's original cash recommendations. However, higher levels of GDP mean that, as a proportion GDP, NHS spending has been about 0.3 per cent lower than the review suggested.

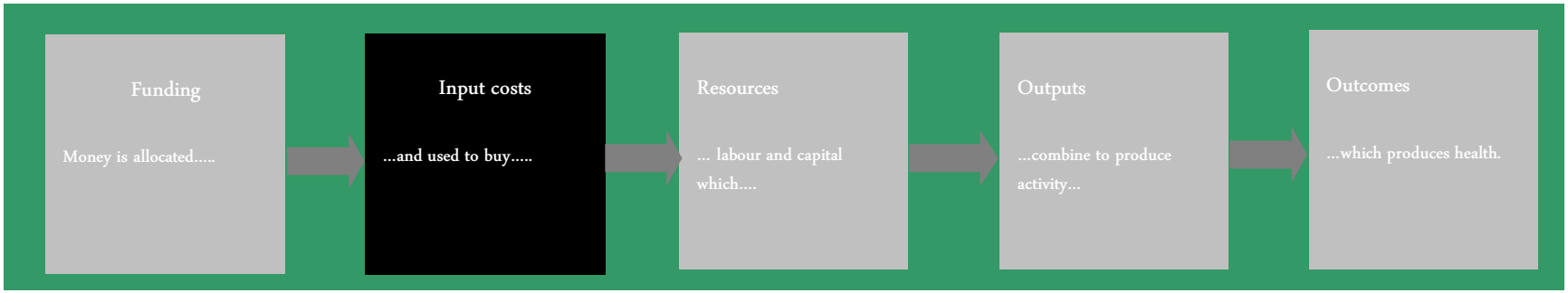
Total NHS and private funding in the UK in 2007/8 now stands at around £113.5 billion (£96.5 billion on the NHS and an estimated £17 billion on private care). This takes UK total health spending into the bottom of the range for estimated average EU-15 health care spending in 2007/8.

If NHS funding increases from 2008/9 reverted to the historic average of around 35 pa, all other things being equal, total health care spend at 2002/3 prices would by 2012/3 fall short of the fully engaged spending path by around £7.2 billion, the solid progress path by £9.2 billion and the slow uptake path by £15.2 billion.

14 HISTORIC AND PROJECTED UK AND EU SPENDING ON HEALTH CARE, 1960 TO 2030



Source: King's Fund analysis; Organisation for Economic Co-operation and Development 2007; Wanless 2002
Notes:
Projections for EU spending are based on historic trends.
Spending figures for EU are a weighted average of EU countries (that is, 15 countries) as at 2000.



Of the £43.2 billion cash increase in UK NHS spending between 2002/3 and 2007/8, an estimated £18.9 billion (43%) was absorbed by higher input costs.

Estimates of combined pay and non-pay NHS inflation between 2002/3 and 2007/8 closely matched the 2002 Review's inflation assumptions. However, actual pay inflation exceeded the Review's assumptions while actual non-pay inflation was slightly lower.

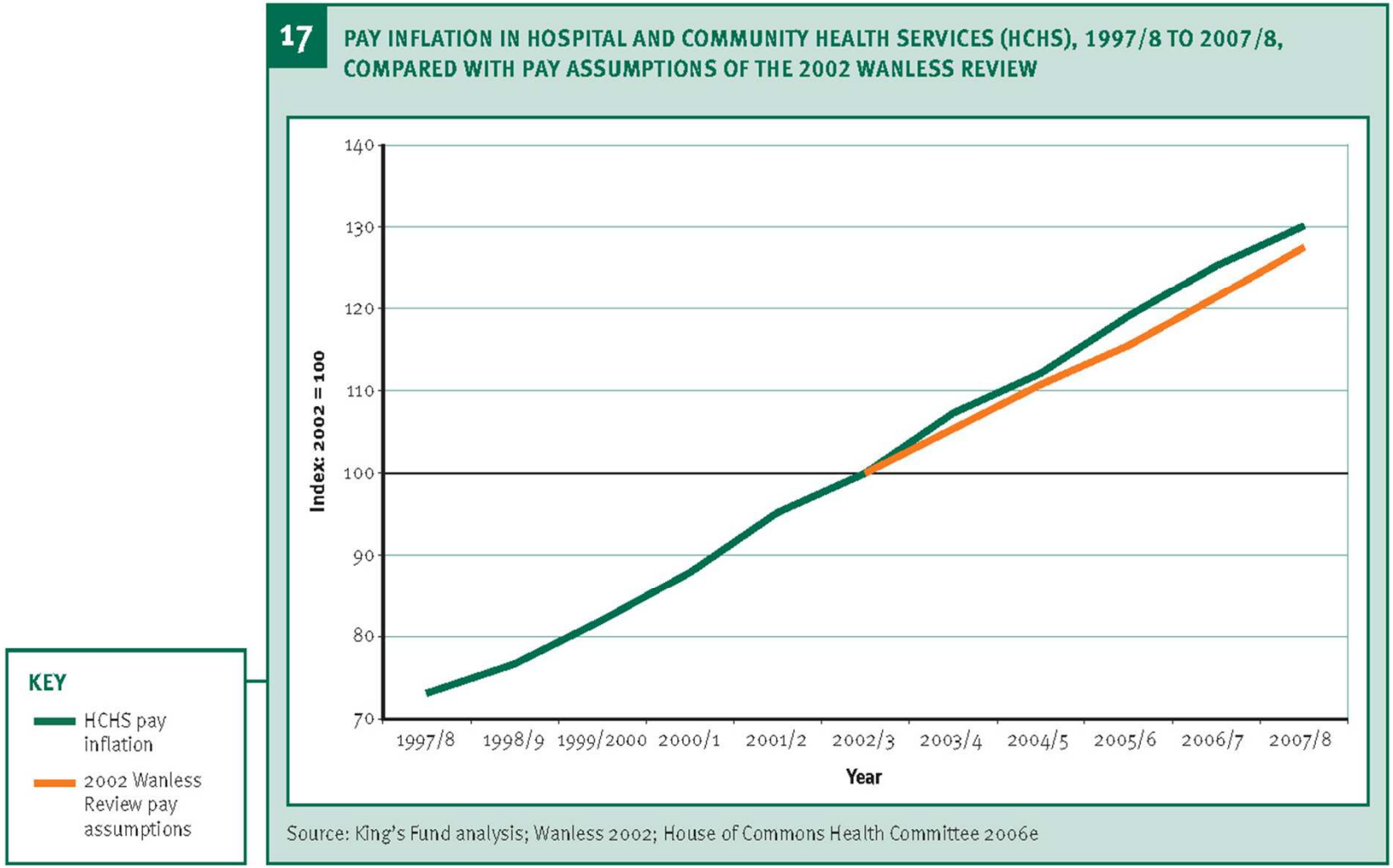
The main source of higher costs has been pay increases arising from three new contracts introduced in the last four years - Agenda for Change (covering all non-doctor staff); and new contracts for hospital doctors and general practitioners.

The cumulative additional cost of Agenda for Change from 2005/6 to 2007/8 has been around £1.8 billion. Consultant pay rates under their new contract increased by around 25% and for GPs their new contract provided an average net increase in income of 23%.

There is some tentative evidence that these new contracts and pay rises may have reduced three-month vacancy rates for the staff groups involved. There is also some indicative sign that consultant and nurse productivity (based on the very crude measure of admissions per member of staff) may be starting to improve compared to falls since 1999.

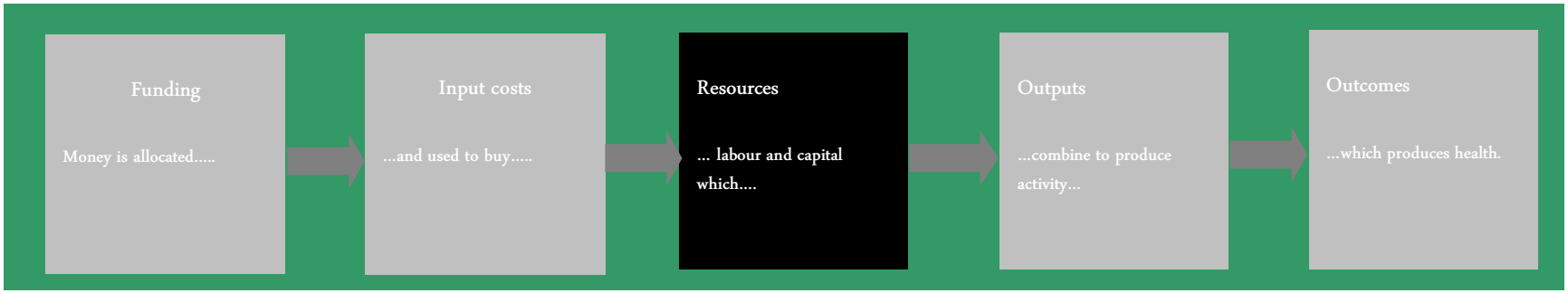
However, more generally, there is a dearth of robust evidence of significant productivity or other benefits arising from the new contracts and pay deals.

17 PAY INFLATION IN HOSPITAL AND COMMUNITY HEALTH SERVICES (HCHS), 1997/8 TO 2007/8, COMPARED WITH PAY ASSUMPTIONS OF THE 2002 WANLESS REVIEW



Source: King's Fund analysis; Wanless 2002; House of Commons Health Committee 2006e

NB: NHS-specific inflation rates from 2005/6 to 2007/8 King's Fund estimates based on tariff uplift information on English HCHS non-pay inflation



The NHS Plan in 2000 set out a 'shopping list' of staff and other resources. Broadly, these have either been, or are, on target to be met.

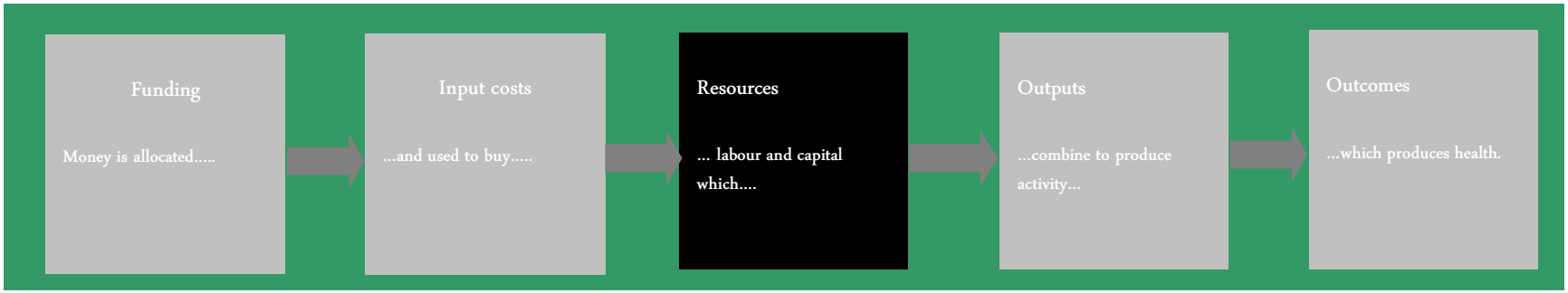
The commitment to increasing the number of NHS staff was targeted for 2004. By 2005, the NHS Plan goals for increases in the workforce were exceeded; consultant numbers were 16% above target, GPs, 166% above; nurses, 272 % above and AHPs, 102% above.

However, the 2002 Review estimates for staff numbers up to 2022/3 suggest that even more staff will be required in the relatively near future.

Non-medical staff numbers have increased substantially, but at a lower rate than medical staff numbers. The ratio of the former to the latter is at its lowest level for more than ten years.

Although the Government appears to be on track to deliver its NHS Plan targets of an additional 100 new hospitals by 2010 and modernisation of over 3,000 GP premises, it seems highly unlikely that the 2002 Review's more ambitious aspirations of replacing one third of the hospital and community health estate by 2022-23 and upgrading the entire primary care estate by 2010-11 will be met.

Backlog maintenance has increased by a fifth between 2000 and 2005 rather than reduced by a quarter as envisaged by the NHS Plan.



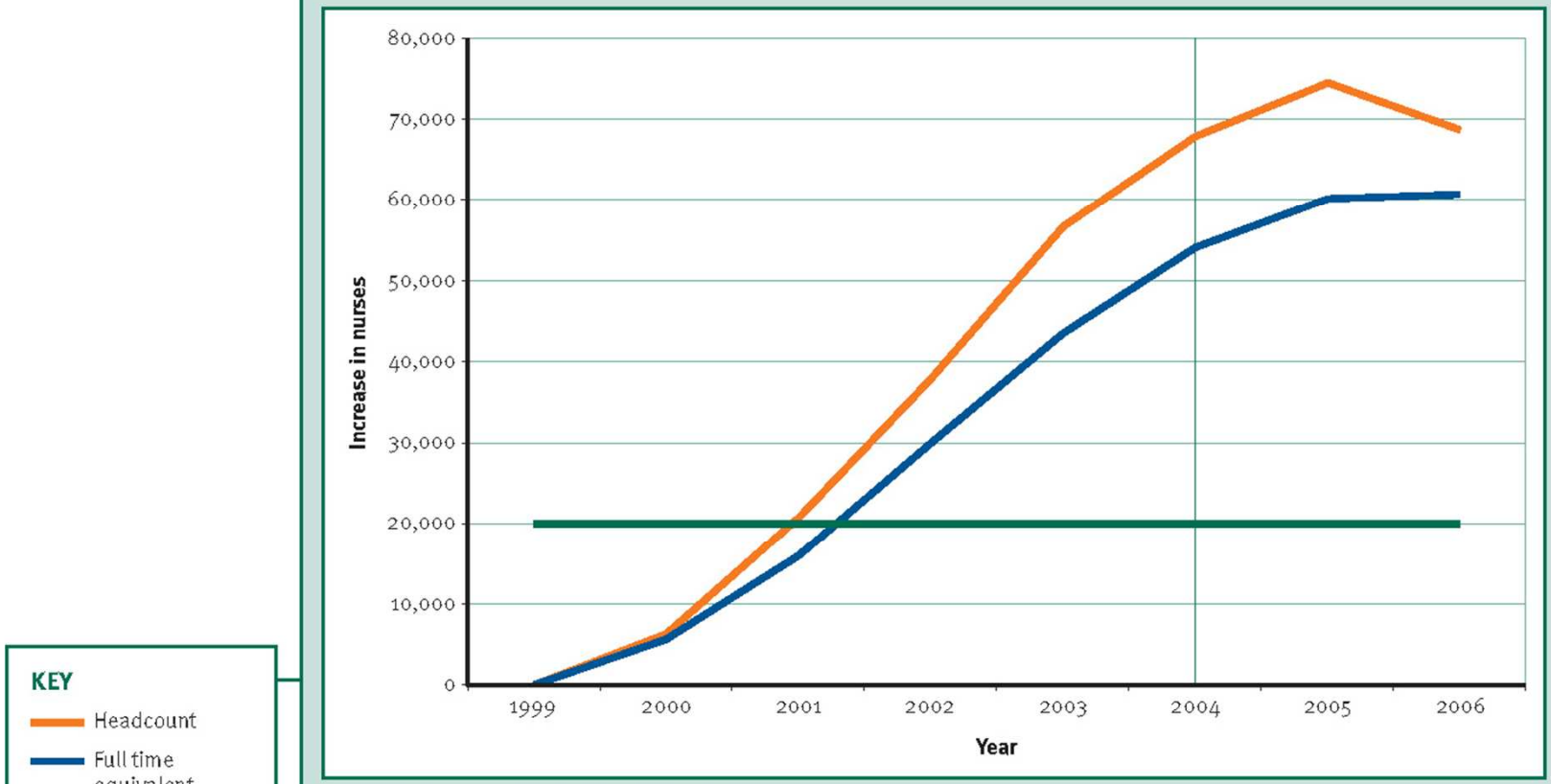
Investment since the NHS Plan in new scanning equipment has meant that around three quarters of MRI, CT scanners and Linear Accelerators now in use in the NHS are new.

The 2002 Review identified better use of information and communications technologies as a key area that offered the potential for productivity and health gains. The Review suggested a need to double ICT spend by 2003-04, peaking at around £2.7 billion in 2007-08, in the solid progress and fully engaged scenarios.

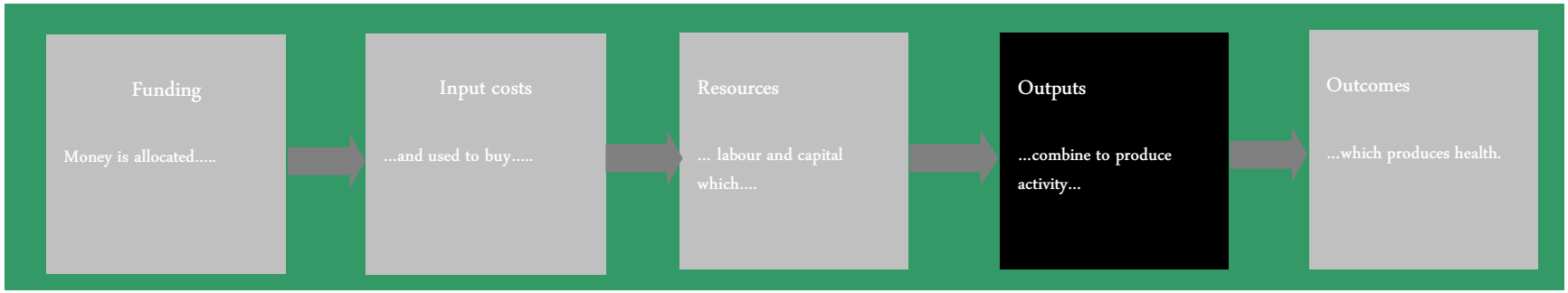
Actual ICT spending in England is estimated to have increased from £1 billion in 2002-03 to £2.3 billion in 2005-06. Actual spending on ICT in the NHS in 2003-04 was around £0.7 billion lower than that envisaged in the solid progress and fully engaged scenarios. Our analysis suggests that the ICT resources set out in the 2002 Review would be sufficient to cover the £12.4 billion estimated cost of the 10 year programme.

The extent to which the NHS will benefit from these substantial investments remains unclear. Three factors seem likely to have an impact on the 2002 Review's productivity assumptions. The first concerns the failure, so far, to develop an ICT strategy whose benefits are likely to outweigh costs, the second is that the 2002 Review assumed that investments would be audited and evaluated, and the third factor is that the NPfIT contracts risk creating monopolies in various areas of the Programme. These factors along with delays to the Programme have the potential to seriously undermine the productivity gains envisaged in the 2002 Review.

26 CUMULATIVE INCREASE IN THE HEADCOUNT AND FTE* NUMBER OF NURSES, 1999 TO 2006, COMPARED WITH THE 2004 NHS PLAN TARGET



Source: King's Fund analysis; Information Centre 2007c
* Full time equivalent



With increased resources, the NHS has been able to do more work in most areas.

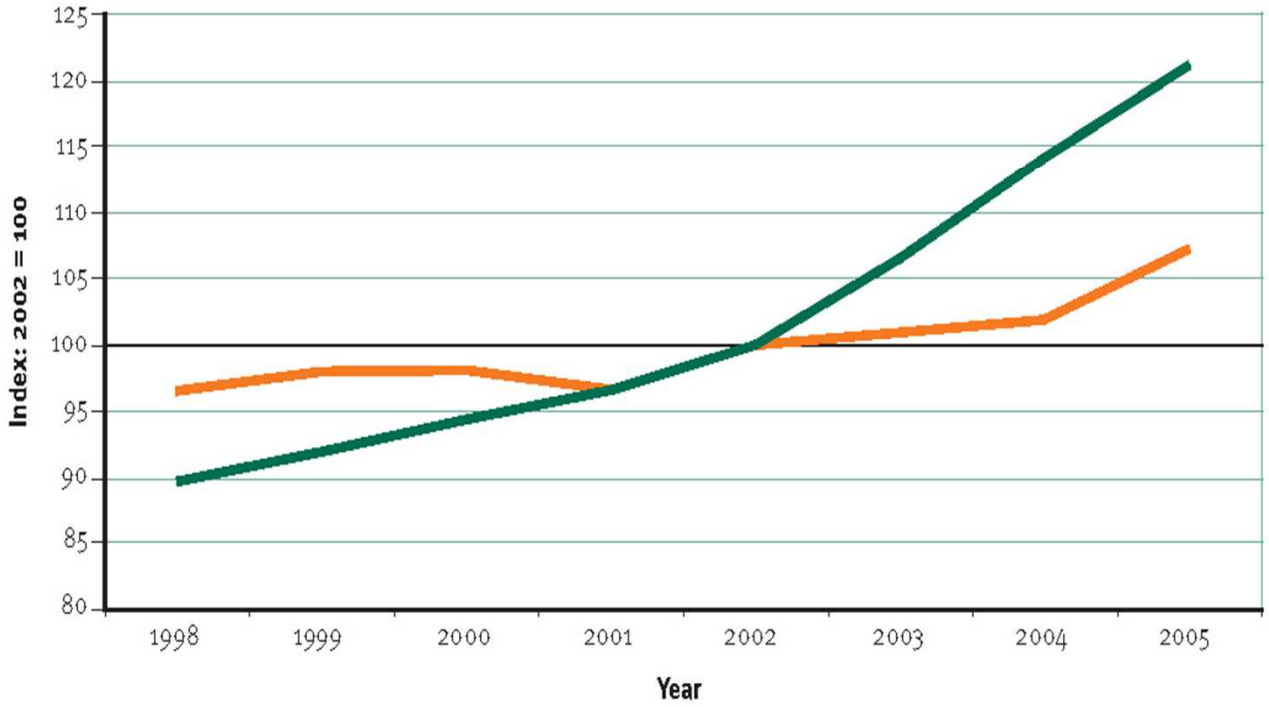
Elective admissions increased by seven per cent between 2002/3 and 2005/6 and outpatient attendances by three per cent.

Virtually all the increase in elective admissions was due to a 22 per cent increase in planned cases, with just a three per cent increase in patients admitted from waiting lists (including booked admissions).

There have also been very large increases in emergency care (+21 per cent) and accident and emergency attendances (+33 per cent), which does not necessarily imply health gain for patients or efficient use of NHS resources.

Three quarters of the 20 per cent increase in prescription items dispensed between 2002/3 and 2006/7 is due to just 10 drugs. Lipid-regulating drugs (statins) account for nearly a fifth of the total increase and are on target for achieving the 2002 review's recommendations at a lower-than-expected cost (Wanless 2002).

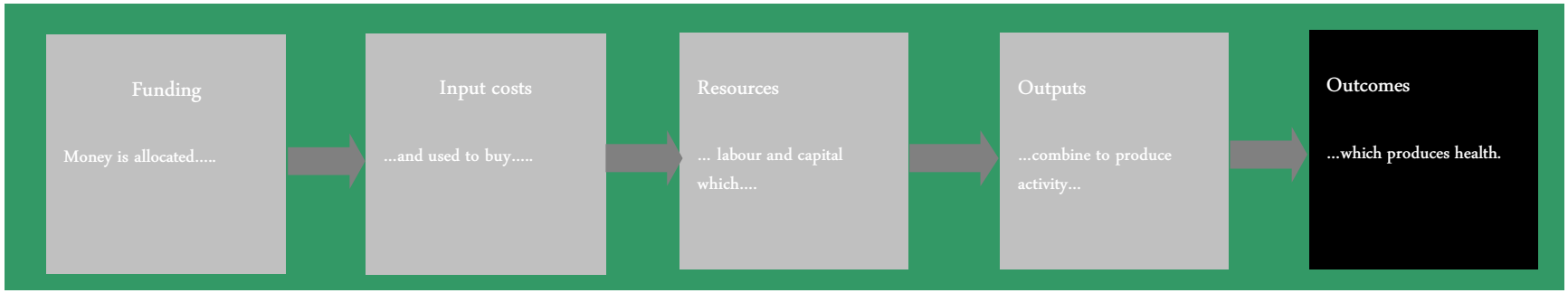
42 TRENDS IN TOTAL ELECTIVE AND NON-ELECTIVE ADMISSIONS, 1998 TO 2005



KEY

- Non-elective
- Elective

Source: King's Fund analysis; Hospital Episode Statistics 2007



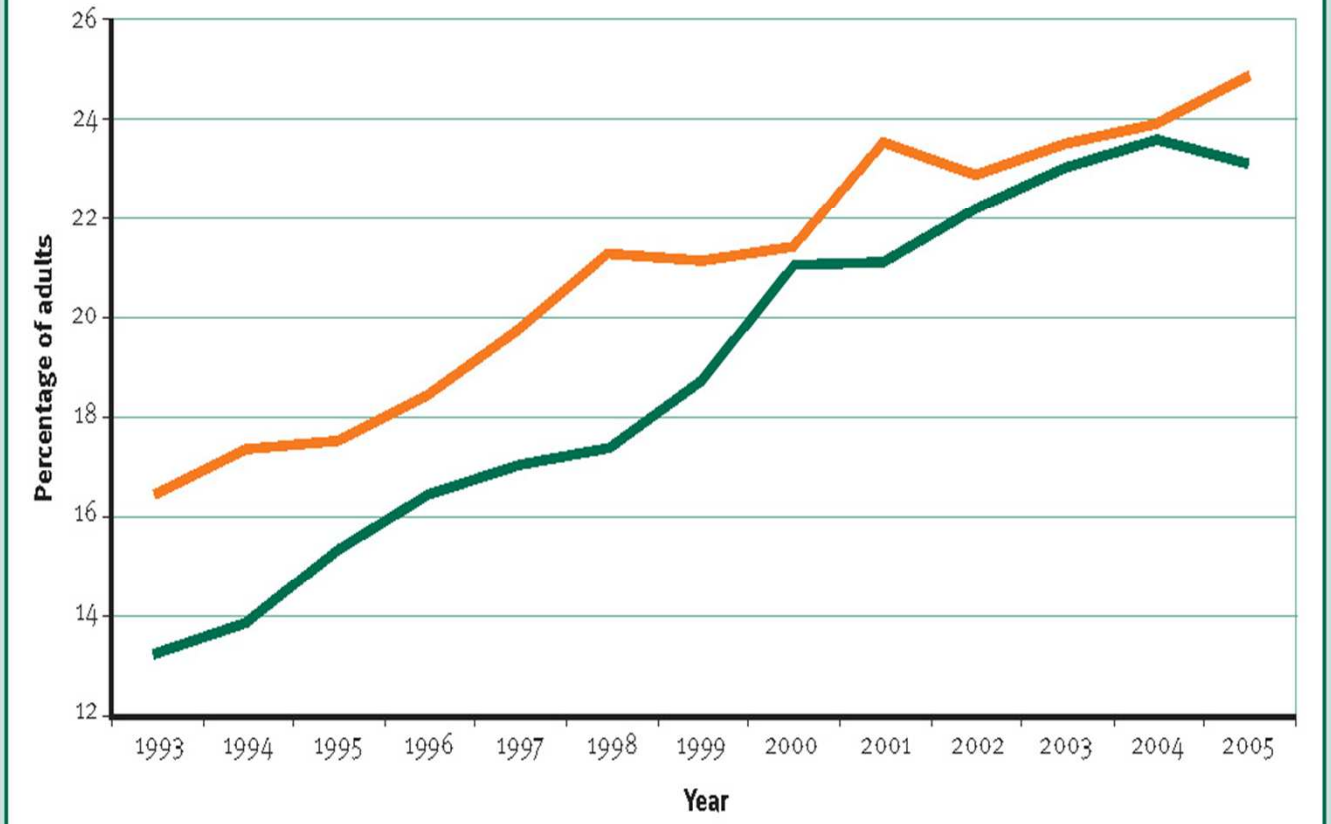
Assessing the overall contribution of the NHS to improvements in patient and public health is extremely difficult and hampered by the lack of routine information on changes in patients' health status.

On broad measures, the health of the population has improved: overall mortality rates have fallen and life expectancy has increased, although both of these developments are continuations of long-term trends. Cancer survival rates have also increased. Infant and perinatal mortality rates have improved a little since 2002 but are still higher than for many other European countries. And various measures of morbidity, such as longstanding illness, remain unchanged.

Tackling the causes of ill health is an ongoing long-term task. Continuing reductions in smoking and improvements in levels of physical activity and diet suggest a future close to the solid progress scenario. But over-optimistic targets – such as those relating to obesity – make it difficult to assess engagement levels in relation to the 2002 review scenarios. Overall, however, the evidence suggests that the population is on a path between slow uptake and solid progress.

Given the lack of accurate information on public health expenditure since 2002, it is impossible to assess whether the fully engaged aspirations for a doubling in public health spending by 2007/8 have been met. Tackling recent financial difficulties in the NHS by raiding public health budgets has not been in the long-term interests of the public's health.

70 PERCENTAGE OF OBESE ADULTS, BY GENDER, 1993 TO 2005



KEY

Male

Female

Source: Information Centre 2006a

Productivity

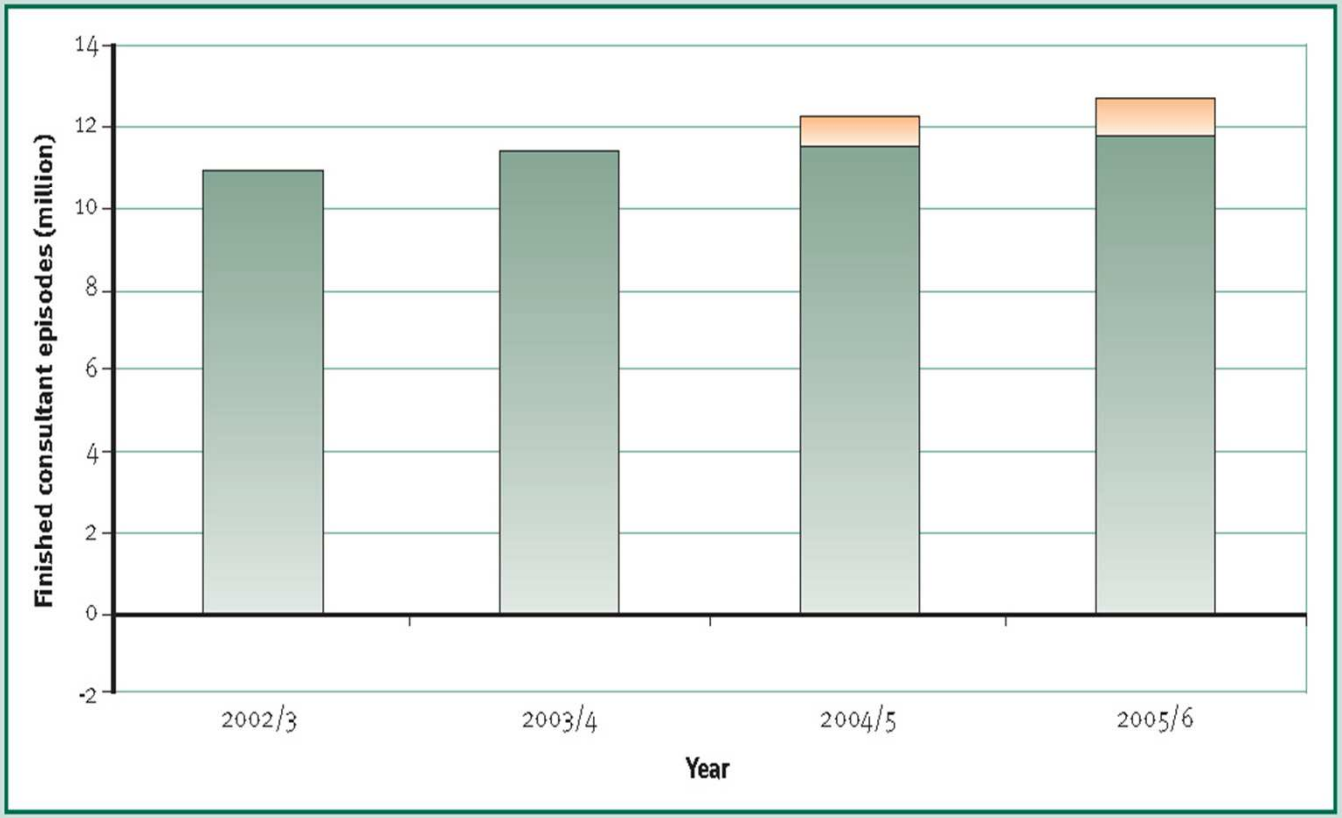
Official measures of NHS productivity provide inconclusive evidence of improvements.

The 2002 review's productivity assumptions of annual unit cost reductions of 0.75-1 per cent between 2002/3 and 2007/8 have not been achieved; broadly, unit costs have increased for all hospital services (Wanless 2002).

Although indicative measures of quality, such as waiting times, and patient satisfaction, suggest improvement, 'hard' measures of quality, valued in monetary terms, are not available to compare with the review's assumption that the quality of care would improve year on year.

Some evidence suggests that the failure to reduce unit costs may have been partially offset by improved quality. However, the NHS has significantly failed to generate the relatively modest improvements in unit cost productivity that might have been expected and were assumed by the 2002 review

116 ADDITIONAL ACTIVITY THAT COULD HAVE BEEN PROVIDED IF UNIT COSTS HAD REDUCED IN LINE WITH 2002 WANLESS REVIEW ASSUMPTIONS, 2002/3 TO 2005/6



KEY

- Additional activity possible if unit costs reduced by 1% pa
- Actual emergency and elective activity

Source: King's Fund analysis; Wanless 2002; National Reference Costs 2007

Policy framework

The Government was right to take the view in 2000 that fundamental reform was required if the NHS was to improve its performance and make effective use of the resources at its disposal. The areas where the most notable improvements have been made, waiting times and other aspects of service quality promoted by National Service Frameworks, have been centrally driven.

It was also right to acknowledge that the approach it initially developed had to evolve. King's Fund research suggests that while the pressure to improve performance exerted by targets and active central management produced positive results, it also made some kinds of changes - those requiring a longer term perspective - harder to achieve. Furthermore, targets alone cannot achieve the across the board improvements in cost and quality that are needed.

Changes in organisational structure have created an environment in which careful planning across a number of organisations has been hard to achieve. Although the new organisational structure may prove more effective than that in place in 1997, it is difficult to identify significant improvement resulting from the recent combination of changes.

Although it is hard to demonstrate the contribution of service redesign, it is clear that improvement in access to cancer and other services and the quality of care available could only have been achieved by changing the way that services are delivered .

The central question, "Which have been the most effective routes to improvement?" is impossible to answer in a rigorous way. The evidence available for estimating the impact of the wide range of policies the Government has pursued is extremely limited. Evidence about the accumulation of present policies must be collected and analysed in the immediate future.

Recommendations

- **Continue to encourage use of recent system reforms to achieve desired results**
- **Monitor and assess policy and performance**
  - Strengthen policy evaluation
  - More research on service reconfiguration
  - Carry out primary care experiment
  - Evaluate NHS IT programme
- **Produce regular long term resource estimates**
  - Treasury/Department of Health to establish mechanism for commissioning and publishing long-term health care resource estimates
  - Define scope and nature of health and social care services
  - Update and expand national service frameworks
  - Better evaluation of link between costs and benefits
  - Invest in research into workforce forecasting and evaluate impact of new staff contracts

Recommendations

- **Measure and manage productivity**
  - Incentive systems to improve productivity should focus on clinical quality and outcomes
  - Large-scale trials of the routine use of measures of health status for NHS patients
- **A framework for public health**

Conclusions

- More money has helped deliver notable improvements in the NHS
  - More and better paid staff
  - More and better equipment and improved infrastructure
  - Shorter waiting times
  - More activity
- As far as can be currently assessed, policy direction is right – but efforts to devolve power to the frontline have been slow and uncertain and evaluation of major policy initiatives is essential
- Also…
  - Productivity improvement has been poor
  - Undesirably large increases in emergency and A&E activity
  - Some key determinants of health moving in the wrong direction, particularly obesity, and the framework for public health spending has not been introduced
- Without improvements in productivity and greater efforts to tackle the causes of ill health, even higher levels of investment in the NHS will be required than envisaged by the fully engaged or solid progress scenarios.